MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-a X

CERTIFICATE OF DEATH

01145

Reg. Dist. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Colesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
The Montgomery County General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Spencerville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Margaret Albright

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Mr. John Albright
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1916

8. AGE:

Years	Months	Days	If less than one day
31	1	13	hrs. min.

9. Birthplace Wheaton, Montgomery Co., Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home

FATHER
12. Name Raymond Case
13. Birthplace Silver Spring, Md.

MOTHER
14. Maiden name Sophie Moore
15. Birthplace Elkton, Md

16. Informant Hospital records.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 25 1947 (month) (day) (year)
Cemetery or crematory Union Cemetery
Location Burtonsville, Md.
18. Funeral director Harry E. Pumphrey
Address Silver Spring, Md.

19. 4-24-1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1947, at 1:32 A.M.

21. I CERTIFY that death occurred on the date above stated: 1bat I attended deceased from February 28 1947, to April 23 1947.
and that I last saw h.s.v. alive on April 23 1947.

Immediate cause of death	DURATION
Carcinoma of cervix	1½ yrs.
general metastasis	
Due to	
Due to	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the canse to which death should be charged statistically.

22. VIOLENCE: If death wes due to externel causes, fill in the following:
Accident, suicide, or homicide Date of
Where did tojury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Richard A. Yates M.D.
M. D. or other
Address Sandy Spring, Md. Date signed 4/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-a)

CERTIFICATE OF DEATH

01146

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: (If outside city or town limits, write RURAL und give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: SUBURBAN
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: WASHINGTON, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3624 - BRANDYWINE
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: JAMES W. BERRY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: KATHARINE L. BERRY
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Sept. 27 - 1886

8. AGE: Years	Months	Days	If less than one day
60			hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: Attorney
11. Industry or business:

FATHER
12. Name: James Berry
13. Birthplace: Md.

MOTHER
14. Maiden name: Ella Huntt
15. Birthplace: Md.

16. Informant: Katharine L. Berry
Address: 3624 - Brandywine

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-7-47 (month) (day) (year)
Cemetery or crematory: Mt. Hebron
Location: Winchester, Va.
19. Funeral director: Joseph Gawlers Son
Address: 1736 Penna Ave, N.W.

19. 4/4 1947 (Date rec'd by registrar) Wm E Gales Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 April 1947 at 100 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 March 1947 to 4 April 1947 and that I last saw him alive on 3 April 1947

	DURATION
Immediate cause of death: Myocardial failure acute,	3 days
Due to: Heart block, complete idioventricular rhythm,	Unknown
Due to: cause undetermined	
Other conditions: Enlarged heart	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Stewart Ladd, M.D.
M. D. or other
Address: 3921 Ingomar St. Wash. D.C. Date signed 4 April '47

Evidence to change date of birth shown in
letter from Dr. Frank J. Bro
chart Film No. G 110 5/10/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

01147

RECEIVED

Reg. Dist. No. .....

APR 12 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day.

Hospital, institution, or street address where death occurred:
Manor Country Club

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County: .....

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 138 W. Sh. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3. (a) FULL NAME: Benjamin F. Bomar

3. (b) Social Security Number: .....

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
male	Col	married

6.(b) Name of husband or wife: Evelyn Bomar

6.(c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): April 24, 1901

8. AGE:

Years	Months	Days	If less than one day
46	11		..... hrs. ..... min.

9. Birthplace: S. C.
(Town, county, and state)

10. Usual occupation: Waiter

11. Industry or business: .....

FATHER
12. Name: Benjamin Bomar
13. Birthplace: S. C.

MOTHER
14. Maiden name: Jennie ?
15. Birthplace: S. C.

16. Informant: Mrs. Evelyn Bomar
Address: 138 W. St. N.W. Washington, D.C.

17. Remoal (Burial, cremation, or removal. Which?) Date thereof: April 15, 1947 (month) (day) (year)

Cemetery or crematory: Remoal

Location: Washington D. C.

18. Funeral director: W. Ernest Jarvis Co.

Address: 1432 - You St. N.W. Wash. D.C.

19. 4-17 1947
(Date rec'd by registrar)

B. J. Snyder per Estherlynn P. Thompson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12, 1947, at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946 to April 12 1947
and that I last saw h... alive on April 12 1947

	DURATION
Immediate cause of death:	
Coronary occlusion	died suddenly
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Brockhurst M.D.
Sept 1946 to April 12 1947 M. D. or other

Address: Gaithersburg Md. Date signed: 4-12-47

01148

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 414

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred:
628 Wayne Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montg
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 628 Wayne Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mordecai Victor Borning

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 1870

8. AGE:

Years	Months	Days	If less than one day
76	10	9	hrs. min.

9. Birthplace Manchester Md
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Mordecai Borning
13. Birthplace Maryland

MOTHER
14. Maiden name Eliza Burns
15. Birthplace Maryland

16. Informant Edith Burk
Address 628 Wayne ave Silver Spring Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof April 16 47
(month) (day) (year)
Cemetery or crematory Hampstead
Location Carroll Co. Md
18. Funeral director Edw C Tipton
Address Hampstead Md

19. April 13 19 47 Josephine M Schaffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947, at 3:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946 to 19
and that I last saw h alive on 19

Immediate cause of death

	DURATION
Coronary occlusion	Several days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J Broschart M.D.
M. D. or other
Address Frederick Md Date signed 4-13-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (2nd)

CERTIFICATE OF DEATH

01149

Reg. Diat. No. 218

1. PLACE OF DEATH:

County: Montgomery

City or town: Washington Grove MD
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Fifty Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Washington Gro ve MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: C lara Belle Brake

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William H. Brake

7. Birth date of deceased (mo., day, yr.): March 24. 1858

6.(c) If alive, give age: March 24. 1858 years

8. AGE: Years	Months	Days	If less than one day
89	1	30	hrs. min.

9. Birthplace: Bergton VA.
(Town, county, and state)

10. Usual occupation: House Wife
Home

11. Industry or business

FATHER
12. Name: Joseph Souder
13. Birthplace: Va.

MOTHER
14. Maiden name: Cathern Bashore
15. Birthplace: Va.

16. Informant: Miss. Bessie C. Brake
Address: Washington Grove MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 25. 1947 (month) (day) (year)

Cemetery or crematory: ST. Lukes Luthern

Location: Redland MD.

18. Funeral director: Roy W. Barber

Address: Laytonsville MD.

19. April 25 1947 (Date rec'd by registrar) Abuda G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23 1947, at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942, to Apr 23 1947 and that I last saw her alive on April 23 1947

	DURATION
Immediate cause of death: Acute Cardiac dilatation	20 min.
Due to: Chronic Salvular heart disease	5 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. L. Brochat M.D.
M. D. or other

Address: Gaithersburg md. Date signed: 4-25-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

CHANGES OF NAMES, age, birthdate, burial:::

01150

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILE No. G 11 MAY 8 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1625 Potomac Avenue, S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: 1st W.W.

3.(a) FULL NAME: BRANDENBURG, Grayson Edgar

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W--US	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 17, 1887 7, 1877

8. AGE: Years	Months	Days	If less than one day
69	4	28	hrs. min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: John William Brandenburg, dec
13. Birthplace: Md.

MOTHER
14. Maiden name: Ida Taylor dec.
15. Birthplace: Md.

16. Informant: sister: Mrs. Annie ~~Holbrook~~ E. Holbrook
Address: 1625 Potomac Avenue, S.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 4-16-47/4-18-47 (month) (day) (year)
Cemetery or crematory: Mt. Olive
Location: Frederick, Md.

18. Funeral director: W. W. CHAMBERS
Address: 517 11th St., S.E., Wash., D.C.

19. 4-15 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 April 1947 at 5:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 April 1947 to 15 April 1947 and that I last saw him alive on 15 April 1947

Immediate cause of death	DURATION
Embolism, pulmonary	1 Hour
Due to Hypertensive Heart Disease	2 yrs
Due to Arterio sclerosis, generalized	Indefinite.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. H. McMILLAN, Capt. (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 4-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

4/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01151

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 days

Hospital, institution, or street address where death occurred:
U.S.N.Hos. Bethesda Md.

How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Alexandria
(If outside city or town limits, write RURAL and give nearest town)

Street No. 110 East King Street
(If rural, give LOCATION)

2.(a) If veteran, name war: 1st WW

3.(a) FULL NAME: James Melvin BRANEGAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 11, 1869

8. AGE: Years	Months	Days	If less than one day
77	4	24	hrs. min.

9. Birthplace: West Va.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: friend: Mrs. Myrtle Johnson
Address 110 East King St., Alexandria, Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-9-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington Va.

W.B. mm.

18. Funeral director: Cunningham Funeral Directors

Address 809 Cameron St. Alexandria Va.

19. 5 April 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 April 19 47 at 1:29 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 March 19 47, to 6 April 19 47 and that I last saw him alive on 6 April 19 47

Immediate cause of death	DURATION
Tuberculosis, Miliary	4 weeks
Tuberculous pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Tuberculosis, Miliary

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. L. Jones Jr. H. L. JONES, Jr. Cdr. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed 4-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

4/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-E)

CERTIFICATE OF DEATH

01152

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Germantown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Germantown, Route #2
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3. (a) FULL NAME: BRIDGEMAN, William Franklin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Maggie Bridgeman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 23 September 1890

8. AGE: Years	Months	Days	If less than one day
56	6	10	..... hrs. ..... min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual occupation: Veteran

11. Industry or business

FATHER — 12. Name: Benjamin F. Bridgeman dec.

13. Birthplace: Va.

MOTHER — 14. Maiden name: Barbara Bridgeman dec.

15. Birthplace: Va.

16. Informant: wife: Mrs. Maggie Bridgeman

Address: Route #2, Germantown, Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 4-4-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 4-2- 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 April 1947 at 1:05A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 8 March 1947 to 1 April 1947

and that I last saw him alive on 1 April 1947

Immediate cause of death	DURATION
Due to: Bronchogenic Carcinoma with Metastases	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. M. C. SMITH, Comdr. (MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 4-2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

01153

Reg. Dist. No. 7-14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred: 306 Normandy Dr

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 306 Normandy Dr

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Anna Cecilia Bruen

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife: Edward J. Bruen

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 9 1867

8. AGE: Years: 79 | Months: 11 | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Brooklyn N.Y. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Thomas Walsh

13. Birthplace: Queen's County, Ireland

MOTHER — 14. Maiden name: Mary Ryan

15. Birthplace: Ireland

16. Informant: Mrs. M E Ramos

Address: 306 Normandy Dr, Silver Spring

17. Removal (Burial, cremation, or removal. Which?) Date thereof Apr 12 1947 (month) (day) (year)

Cemetery or crematory:

Location: Alexandria Va.

18. Funeral director: Howe E Pumphrey

Address: Silver Spring Md.

19. Apr. 10 1947 (Date rec'd by registrar) Josephine M. Schaefer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 April 1947 at 9:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 March 1947 to 9 April 1947 and that I last saw h... alive on 9 April 1947

Immediate cause of death	DURATION
Senility	—
Due to	
Due to	
Other conditions: Generalized Arteriosclerosis	7

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William D. Ruff M.D. M. D. or other

Address: Silver Spring Md. Date signed Apr 10 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (175-a)

CERTIFICATE OF DEATH

RECEIVED 01154

Reg. Dist. No. 11-7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Gaithersburg R-2

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother) MONTGOMERY COUNTY

State Maryland County Montgomery

City or town Gaithersburg R.F.D. #3

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war NO

3.(a) FULL NAME Milbert T Butts

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 16, 1914

8. AGE: Years	Months	Days	If less than one day
33	3	1	hrs. min.

9. Birthplace Darnestown, Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Own Farm

FATHER 12. Name John T. Butts

FATHER 13. Birthplace Montgomery Co., Md.

MOTHER 14. Maiden name Duel-l Gloyd

MOTHER 15. Birthplace Baltimore, Md.

16. Informant Naomi B. Wheeler

Address 319 Beall Ave., Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/20/47 (month) (day) (year)

Cemetery or crematory Darnestown Church Cem.

Location Darnestown, Md.

18. Funeral director Wm Reuben Pumphrey

Address 7557 Wisconsin Ave., Bethesda, Md.

19. 4-21 1947 (Date rec'd by registrar) E P Thompson B. F. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 17 1947, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 17 1947 to 1947

and that I last saw h alive on 1947

Immediate cause of death	DURATION
Inter cranial hemmorage due to fracture of skull	hours minutes
Due to (accidental)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 4-17-47

Where did injury occur? Gaithersburg (City or town) R-3 (County) Monty (State) md

Injured at home, farm, industry, public place (where?) farm

Means of injury Crushed by tractor Injured at work? yes

23. SIGNATURE Frank J. Broschart M.D. M. D. or other

Address Gaithersburg md Date signed 4-17-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14a)

CERTIFICATE OF DEATH

01155

Reg. Dist. No. 212

M

1. PLACE OF DEATH:
County Montgomery
City or town Boyd - R.F.D. (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 58 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Montg
City or town Boyd - Rural, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Clay Thomas Carlin

3.(b) Social Security Number 216-22-2467

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11 - 1889

8. AGE: Years 58 | Months 2 | Days 24 | If less than one day hrs. min.

9. Birthplace Boyd, Monta. Co., Md (Town, county, and state)

10. Usual occupation Manager of Amusement

11. Industry or business Park

FATHER
12. Name John T Carlin
13. Birthplace Md.

MOTHER
14. Maiden name Francis R Himmell
15. Birthplace Md

16. Informant Leslie Carlin
Address Boyd - RFD Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 8-47 (month) (day) (year)
Cemetery or crematory St. Mary's
Location Barnesville, Md

18. Funeral director William B Hilton
Address Barnesville, Md

19. April 7 1947 (Date rec'd by registrar) Mrs. C. C. Hilton By mw. w. B. H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5th 1947, at 2.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1946 to Apr. 5th 1947 and that I last saw h.. alive on Apr. 1st 1947

Immediate cause of death	DURATION
Acute Coronary Thrombosis	10 min
Due to Sclerosis of the Coronary arteries	5 yrs
Due to	
Other conditions Chronic Sinusitis	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Helen S Mount M.D. M. D. or other
Address Barnesville Md Date signed
P.O. Boyds. Md.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

01156

Reg. Diat. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Brookeville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Cashell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 3, 1947

8. AGE: Years | Months | Days: 8 | If less than one day: ..... hrs. ..... min.

9. Birthplace Olney, Montgomery Co. Md.
(Town, county and state)

10. Usual occupation Infant.

11. Industry or business

FATHER
12. Name George Franklin Cashell Jr.
13. Birthplace Sunshine, Maryland.

MOTHER
14. Maiden name Margaret Marie Purcell
15. Birthplace Colesville, Maryland.

16. Informant Hospital records.
Address

17. Burial (Burial, cremation, or removal, Which?) Date thereof April 12, 1947 (month) (day) (year)
Cemetery or crematory Mt Carmel
Location Norbeck Co Md

18. Funeral director Joseph W. Barber
Address Laytonsville Md

19. 4-12-1947 Gertrude Lawson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1947, at 6:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 1947, to April 11 1947
and that I last saw him alive on April 11 1947

Immediate cause of death	DURATION
Prematurity - Smts -	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. M. Bell M. D. or other
Address Sandy Spring, Md Date signed 4-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (29)

CERTIFICATE OF DEATH

01157

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital, Geo. Rd. -

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8300 - Rundette Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Carla Wooten Clark (Infant)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 7 - 1947

8. AGE: Years	Months	Days	If less than one day
			hrs. 57 min.

9. Birthplace Bethesda Montgomery Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Maurice Wilbur Clark

13. Birthplace Silver Spring Maryland.

MOTHER

14. Maiden name Gladys Virginia Cooper

15. Birthplace Pennsylvania Co. Virginia

16. Informant Maurice Wilbur Clark

Address 8300 - Rundette Rd. Bethesda Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof April 9 1947 (month) (day) (year)

Cemetery or crematory Suburban Hospital

Location Bethesda 14 Md

18. Funeral director A B. Solon Supt

Address Bethesda, Md

19. 4/12 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1947, at 1.15 P.M.

21. I CERTIFY that death occurred on the date above etated; that I attended deceaeed from April 7 1947, to April 7 1947

and that I last saw h.i.m. alive on April 7 1947

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operatioos

Date of op.

Aotopsy resolts

PHYSICIAN: Please underline the caose to which death should he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. L. Drake M.D.

M. D. or other

Address Date signed 4/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

01158

CERTIFICATE OF DEATH

Reg. Dist. No. 316

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital, Geo. Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8300 - Burdette Rd,
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James Marion Clark (Infant)

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): April 7 - 1947

8. AGE: Years / Months / Days / If less than one day: 1 hrs. 20 min.

9. Birthplace: Bethesda, Montgomery, Maryland.
(Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name: Maurice Wilbur Clark
13. Birthplace: Silver Spring Maryland

MOTHER
14. Maiden name: Gladys Virginia Cooper
15. Birthplace: Spotsylvania Co. Virginia

16. Informant: Maurice Wilbur Clark
Address: ~~Silver Spring~~ Beth - Maryland.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: April 9 1947 (month) (day) (year)
Cemetery or crematory: Suburban Hospital
Location: Bethesda 14. Md

18. Funeral director: A. B. Solon, Supt
Address

19. 4/12 1947 (Date rec'd by registrar) Wm E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7 1947 at 1:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7 1947, to April 7 1947 and that I last saw him alive on April 7 1947.

Immediate cause of death: Prematurity

DURATION

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: R. L. Marker M.D. (M. D. or other)
Address: 4601 Leland St. Date signed: 4/8/47

VS A15 9-45-15M


RECEIVED
APR 14 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

01159

Reg. Dist. No. 714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
816 Philadelphia Ave.,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 816 Philadelphia Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: JOHN MILTON COLLINS

3.(b) Social Security Number: none

4. Sex: male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Nellie Amelia Thorman
6.(c) If alive, give age: ....years
7. Birth date of deceased (mo., day, yr.): Dec. 6th. 1875
8. AGE: Years: 71 Months: 4 Days: 17 If less than one day: ....hrs. ....min.
9. Birthplace: Washington, Kansas (Town, county, and state)
10. Usual occupation: Trademark Lawyer,
11. Industry or business: U.S. Patent Office
FATHER 12. Name: Isaac Collins
13. Birthplace: New York
MOTHER 14. Maiden name: Laura Ann Reynolds
15. Birthplace: New York
16. Informant: Mrs. Nellie A. Collins
Address: 816 Phila. Ave. Silver Spring.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-26-1947 (month) (day) (year)
Cemetery or crematory: Washington National
Location: Suitland, Pr. Geo's Co. Md.
18. Funeral director: Wane & Caughey
Address: Silver Spring, Md.
19. Apr. 24 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 APRIL 1947, at 8:32 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 APRIL, 1947, to 23 APR., 1947
aed that I last saw h..m alive on 23 APRIL 1947

	DURATION
Immediate cause of death: PERIPHERAL CIRCULATORY FAILURE	
Due to: IMPAIRMENT OF VITAL CENTERS	
Due to: CEREBRO-ARTERIOSCLEROSIS AND CEREBRAL HEMORRHAGE	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: L. Marshall Lauvillier Jr. Md.
M. D. or other
Address: 8648 GEORGIA AVE. SILVER SPRING, MD. Date signed: 23 APR. '47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01160

Reg. Diat. No. 714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Kensington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Kensington

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Walter Contee

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colrd	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1871

8. AGE: Years 66 | Months 1 | Days 21 | If less than one day ... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name George Contee

13. Birthplace Maryland

MOTHER 14. Maiden name Caroline Adams

15. Birthplace Kensington, Md.

16. Informant William Adams

Address Kensington, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 13, 1947 (month) (day) (year)

Cemetery or crematory Rockville

Location Rockville, Md.

18. Funeral director Robert L. Snowden

Address Rockville, Maryland

19. April 12 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947, at 8:34 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. Med. Exam 19 ... to ... 19 ...

and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Coronary occlusion	1/2 hr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op. ...

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE Frank J. Bronhart M.D. M. D. or other

Dep. Med. Exam

Address Gaithersburg Md Date signed 4-10-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

01161

Reg. Dist. No. 211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Woodfield Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Eight Months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Woodfield Md Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Della Darby.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Femal	W	Widowed

6.(b) Name of husband or wife Marion Darby

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec 3, 1888

8. AGE: Years	Months	Days	If less than one day
58	3	9	____ hrs. ____ min.

9. Birthplace Montgomery Co Md (Town, county, and state)

10. Usual occupation Home Wife

11. Industry or business Home

FATHER

12. Name Jacob A Allnutt

13. Birthplace Maryland

MOTHER

14. Maiden name Emilmia Warfield

15. Birthplace Maryland

16. Informant Mrs Nellie Lynch

Address Woodfield Md

17. Burial (Burial, cremation, or removal). Which?) Date thereof April 11 1947 (month) (day) (year)

Cemetery or ~~crematory~~ Goshen Md

Location Montgomery Co Md

18. Funeral director Rodgers Barber

Address Laytonsville Md

19. April 11 1947 Della W Burdette

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1947, at 7:45 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5, 1947, to April 9 1947

and that I last saw h.E.R. alive on April 8 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage, left	5 days.
Due to Arteriosclerotic cardiovascular disease	10 years.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James P. Kerr M.D.

M. D. or other

Address Damascus, Md. Date signed 4/11/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-52) X

CERTIFICATE OF DEATH

01162

Reg. Dist. No. 223

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery Co.

City or town ~~Washington D.C.~~ Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 hrs

Hospital, Institution, or street address where death occurred:

Washington Sanitarium + Hospital

How long in hospital or institution? 20 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Kensington, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 42 Decatur

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Maude E. Daynude

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	White	Married

6.(b) Name of husband or wife Ernest Luther Daynude

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jul 4 10: 1900

8. AGE:

Years	Months	Days	If less than one day
46	9	20	..... hrs. ..... min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual occupation Housf.

11. Industry or business

FATHER

12. Name Oliver F Miller

13. Birthplace Baltimore Md.

MOTHER

14. Maiden name Beulah Miller

15. Birthplace Baltimore Md.

18. Informant Mrs Chait

Address Washington Sanitarium

17. Burial, cremation, or removal. Which? Burial Removal Date thereof 4-30-47 (month) (day) (year)

Cemetery or crematory

Location Bethesda, Md.

18. Funeral director Wm R Dunphey

Address Bethesda Md.

19. April 30 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 47 19 ..... at 9 30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10 46 19 ..... to April 29 19 47

and that I last saw h.r. alive on April 29 47 19 .....

Immediate cause of death	DURATION
~~Coronary~~ Cardiac Failure; acute	
Secondary to	
Carcinoma; Cervix; with	1 yr.
Due to: Infect of Urinary Bladder	
Colon - Uterus (Frozen Pelvis)	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations Carcinoma of Cervix & Uterus

Date of op. .....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Samuel Allen MD

M. D. or other

Address Kensington Md Date signed April 30/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (732)

CERTIFICATE OF DEATH

01163
216
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

4/23/47

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1302 18th St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: 1st WW

3.(a) FULL NAME: DE STEIGUER, Louis Rodlph, Admiral USN-Retired Inactive

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W*US	Married

6.(b) Name of husband or wife: Katherine De Steiguer

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-18-67

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
80	2	1		

9. Birthplace: Ohio
(Town, county, and state)

10. Usual occupation: Retired Navy Personnel

11. Industry or business:

FATHER
12. Name: John De Steiguer
13. Birthplace: Ohio dec.

MOTHER
14. Maiden name: Mary Carpenter
15. Birthplace: Ohio dec.

16. Informant: Wife: Katharine De Steiguer
Address: 1302 18th St., N.W., Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-21-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Joseph Gawler's & Sons, Inc. REH

Address: 1756 Penn. Ave., N.W., Wash. D.C.

19. 19 April 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19 April 19 47 at 1005 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 April 19 47 to 19 April 19 47 and that I last saw him alive on 19 April 19 47

Immediate cause of death	DURATION
Thrombosis Coronary Artery	8 days
Due to: Rupture, nontraumatic left ventricle	1-2 min.
Due to: Infarction pulmonary	8 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. V. PACKARD, Capt. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 4-19-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-2

01164

CERTIFICATE OF DEATH

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Montgomery

City or town Rockville, Md Route #2

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville, Route #2

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Dove

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1894

8. AGE: Years	Months	Days	If less than one day
52	8	13	hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Samuel Dove

13. Birthplace Maryland

MOTHER 14. Maiden name Henrietta Mason

15. Birthplace Maryland

16. Informant Henrietta Cooper

Address Rockville, Md. R.F.D. #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 7, 1947 (month) (day) (year)

Cemetery or crematory #10 Cabin Johns

Location Cabins Johns, Md

18. Funeral director Robert L. Snowden

Address 246-N-Wash. St. Rockville Md

19. 4-7 1947 (Date rec'd by registrar) Betty Jane Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1947, at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946, to April 3 1947.

and that I last saw him alive on April 3 1947.

Immediate cause of death	DURATION
Carcinoma of left lung.	1 year
Due to —	
Due to —	
Other conditions none	

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. P. Linthicum M.D. M. D. or other

Address Rockville, Md Date signed 4/4/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16

CERTIFICATE OF DEATH

01165

Reg. Dist. No. 217

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:
County Montgomery
City or town Olney
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Montgomery Co. Gen. Hospital
How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Edward Doye

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25-1926

8. AGE:

Years	Months	Days	If less than one day
20			hrs. min.

9. Birthplace Norbeck Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Richard Budd
13. Birthplace Sandy Spring Md

MOTHER
14. Maiden name Mabel Doye.
15. Birthplace Norbeck Md

16. Informant Mabel Doye (mother
Address Norbeck, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 16, 1947 (month) (day) (year)
Cemetery or crematory Church Cemetery
Location Norbeck, Maryland

18. Funeral director R. L. Snowden
Address Rockville, Maryland

19. 4-16- 19 47 (Date rec'd by registrar) Gertrude B Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947 at 10 45 a.m. p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1947, to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Hemorrhage due to rupture of traumatic aneurysm	
Due to of rt carotid artery of	14 days
Due to gun shot	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Homicide Date of 3-30-47
Where did injury occur? Rockville (City or town) Montg (County) Md (State)
Injured at home, farm, industry, public place (where?)
Means of injury Shot gun Injured at work? no

23. SIGNATURE Dept. med. Examr. David J. Bowstead M.D. M. D. or other
Address Gaithersburg Md. Date signed 4-13-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

01166

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs

Hospital, institution, or street address where death occurred: 42 Sycamore Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Mont

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 42 Sycamore Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ernst Franz Ehnert

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Paula Ehnert

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Dec 4 1958

8. AGE:

Years	Months	Days	If less than one day
88	4	23	...hrs. ...min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Retired Navy Yard Merchant

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace: Germany

MOTHER

14. Maiden name: Unknown

15. Birthplace: Germany

16. Informant: Paula Ehnert

Address: 42 Sycamore ave. Takoma Pk md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 4-29-47 (month) (day) (year)

Cemetery or crematory: Wash. D.C. Crematory

Location

18. Funeral director: J. William Lees Sons

Address: 306 - 4th street N.E.

19. Apr 27 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27 19 47, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1946 19..., to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death: Coronary occlusion

DURATION: final — sudden

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. M. D. or other

Address: Gaithersburg md Date signed: 4-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01167

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Missouri County:

City or town: Kansas City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3417 Harrison Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME

ENLOE, Herbert Towner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 24, 1894

8. AGE: Years	Months	Days	If less than one day
53	0	7	hrs. min.

9. Birthplace: Kansas
(Town, county, and state)

10. Usual occupation: Operations Engineer

11. Industry or business: Federal Works Agency

FATHER
12. Name: David Enloe
13. Birthplace: Iowa dec.

MOTHER
14. Maiden name: Mary Wilson
15. Birthplace: Ky. dec.

16. Informant: bro: Mr. George Enloe
Address: 3417 Harrison St., Kansas City, Missouri

17. removal (Burial, cremation, or removal. Which?) Date thereof: 4-2-47 (month) (day) (year)

Cemetery or crematory:

Location: Kansas City, Missouri

18. Funeral director: W. W. CHAMBERS

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 4-2 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 April 1947 at 9:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31 Dec. 1946 to 1 April 1947 and that I last saw h... alive on 1 April 1947

Immediate cause of death	DURATION
Septicemia	
Due to: Extension of suppurative process in chest	
Due to:	
Other conditions: Empyema	

(Include pregnancy within 3 months of death)

Major findings of operations: Empyema Date of op.

Autopsy results: Empyema, Lung abscess, Septicemia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. B. Ford
W. B. FORD, Lt.(MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 4-2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use (or not) age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

01168

CERTIFICATE OF DEATH

Reg. Dist. No. 716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Brookmont
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years - Her home.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: 6427 - Brooks Lane Brookmont
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6427 - Brooks Lane Brookmont
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Christina Mae Evans

3.(b) Social Security Number: Had none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Ulysses S. Evans

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): May 27 - 1895

8. AGE: Years	Months	Days	If less than one day
51	10	19	___ hrs. ___ min.

9. Birthplace: Knoxville - Tennessee
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Her home

FATHER
12. Name: John Curtis LeTellier
13. Birthplace: Virginia

MOTHER
14. Maiden name: Armanda Frances Humphries
15. Birthplace: Virginia

16. Informant: Ulysses S. Evans
Address: 6427 Brooks Lane Brookmont Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 19, 1947 (month) (day) (year)
Cemetery or crematory: Potomac Church Cemetery
Location: Potomac, Maryland

18. Funeral director: Wm. Reuben Pumphrey
Address: Bethesda 14, Maryland

19. 4/17 1947 (Date rec'd by registrar) M E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16th 1947 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15th 1947 to April 16 1947 and that I last saw her alive on April 16th 1947

Immediate cause of death	DURATION
Chronic myocardial — insufficiency	2 years
Due to: Diabetes mellitus	5 years
Due to:	
Other conditions: Chronic interstitial nephritis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wheeler D. Huff M. D. or other
Address: Bethesda 14 Md. Date signed: Apr 16-1947
-1947

Evidence for change of birthplace shown on: FILM No. G 110 MAY 5 1947

01169

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(92d)

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
4 Elwyn Court

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4 Elwyn Court
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Mable Fern Faling

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Charles P.

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Mar. 8th. 1893

8. AGE: Years	Months	Days	If less than one day
54	1	12	... hrs. ... min.

9. Birthplace: Stella, Mich. Nebraska
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Joseph Auch

13. Birthplace: Penn.

MOTHER — 14. Maiden name: Rebecca Sommers

15. Birthplace: Indiana.

16. Informant: Mr. Charles P. Faling

Address: 4 Elwyn Ct. Takoma Pk. Md.

17. cremation (Burial, cremation, or removal. Which?) Date thereof: 4-23-1947 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Prince Georges Co., Md.

18. Funeral director: Warner E. Pumphrey

Address: Silver Spring, Md.

19 April 24 1947 (Date rec'd by registrar) J. Holton Reg. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1947, at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1946 to Death 1947

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
acute cardiac dilatation	½ hr.
Due to: Chronic Valvular heart disease	9 mo.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

Frank J. Brockett M.D.

23. SIGNATURE: ... M. D. or other

Address: Gaithersburg Md. Date signed: 4-20-47

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

01170

Reg. Dist. No. 2-17

1. PLACE OF DEATH:

County Montgomery

City or town Olney Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Laytonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Mary O. Fulks

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife Vernon Fulks - deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 22, 1881

8. AGE: Years	Months	Days	If less than one day
65	9	21	..... hrs. ..... min.

9. Birthplace Vienna, Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Isaac D. Oliphant

13. Birthplace Laurel, Delaware

14. Maiden name Mary Fooks

15. Birthplace Laurel, Delaware

16. Informant Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 15 - 1947 (month) (day) (year)

Cemetery or ~~crematory~~ Laytonsville md

Location montgomery co md

18. Funeral director Roy W. Barber

Address Laytonsville md

19. 4-14- 1947 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947 at 5:05 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28 1947, to April 13 1947

and that I last saw her alive on April 13 1947

Immediate cause of death	DURATION
Diabetes Mellitus	6 years
Due to Acute gangrenous appendicitis	16 days.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Acute gangrenous appendicitis

Date of op. April 2, 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. W. Bird (J. W. Bird) M. D. or other

Address Sandy Spring, Md Date signed 4/14/47

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

01171

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 weeks
Hospital, Institution, or street address where death occurred: 312 HIGHVIEW AVE.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: WASHINGTON
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3900 - 14TH. ST. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MARY H. GASKINS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife: CHARLES H. GASKINS
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 9, 1856

8. AGE: Years: 90 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: WASHINGTON D.C. (Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business:

FATHER
12. Name: JOHN MULLIN
13. Birthplace: IRELAND

MOTHER
14. Maiden name: CATHERINE NEUGENT
15. Birthplace: IRELAND

16. Informant: CHARLES H. GASKINS
Address: 312 HIGHVIEW AVE. SILVER SPRING, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: APR. 18, 1947 (month) (day) (year)
Cemetery or crematory: ST. MARY'S CEMETERY
Location: WASHINGTON, D.C.

16. Funeral director: Francis J. Collins
Address: 3821-14th St. N.W. Wash. D.C.

19. Apr. 16 1947 (Date rec'd by registrar) Registrar: Josephine M. Schaeffer

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15 1947, at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 14 1947 to April 15 1947
and that I last saw h.. alive on April 15 1947

Immediate cause of death	DURATION
acute coronary occlusion	12 hrs.
Due to arteriosclerotic heart disease	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. Franklin Kenyon M.D. M. D. or other
Address: 7852 16th Wash D.C. Date signed: 4/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01172

CERTIFICATE OF DEATH

Reg. Diat. No. 516

1. PLACE OF DEATH:
County MONTGOMERY
City or town ROCKVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
WAVERLEY SANITARIUM
How long in hospital or institution? 10 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State DIST. OF COL. County
City or town WASHINGTON
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1736 R St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MRS. FREDERICA GILES

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife ROBERT GILES
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) DEC. 22 1861

8. AGE: Years 85 | Months | Days | If less than one day hrs. min.

9. Birthplace WASHINGTON D.C. (Town, county, and state)
10. Usual occupation none
11. Industry or business
MOTHER FATHER
12. Name ADM. JOHN RODGERS
13. Birthplace HARVE DE GRACE, MD
MOTHER
14. Maiden name ANN HODGES
15. Birthplace PHILADELPHIA PA.
16. Informant RECORD OF BROTHER
Address
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof APRIL 8/1947 (month) (day) (year)
Cemetery or crematory OAK HILL CEM.
Location WASH. D.C.
18. Funeral director Joseph Sanders Sons
Address 456 Penna Ave. N.W.
19. 4/7 19 47 Wm E Jones Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1947, at 5-05 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 1947 to April 4 1947
and that I last saw her alive on April 3 1947

	DURATION
Immediate cause of death Cerebral Hemorrhage	11 days
Due to Generalized Arteriosclerosis	15 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation none
Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Walter K Myers M. D. or other
Address 1834 Eye St NW Washington D.C. Date signed 4/4/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1316 01173

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 88 days
Hospital, institution, or street address where death occurred:
USNH, Bethesda, Maryland
How long in hospital or institution? 88 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1423 Corcoran Street, Northwest
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME: GLASGOW, John Thomas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	Married

6.(b) Name of husband or wife: Mrs. Mary V. Glasgow
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 2 November 1889

8. AGE: Years	Months	Days	If less than one day
57	5	24	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: Unknown
FATHER 12. Name: John Glasgow
13. Birthplace: Virginia
MOTHER 14. Maiden name: Caroline Wright
15. Birthplace: Virginia
16. Informant: Mrs. Mary V. Glasgow
Address: 1423 Corcoran St., NW, Wash., D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-30-47 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Virginia
18. Funeral director: L. E. Murray & Son LEM
Address: 1337 10th St, NW, Washington, D. C.
19. 4-26 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 April 1947, at 1:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 January 1947, to 26 April 1947 and that I last saw him alive on 26 April 1947

Immediate cause of death	DURATION
Hypertension, Arterial	1 yr.
Due to: Chronic glomerulonephritis	1 yr.
Due to: Arteriosclerosis, generalized	1 wk.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. B. Bryan J. B. BRYAN, Lt. (jg) (MC) USNR M. D. or other
Address: USNH Bethesda, Md. Date signed: 4-26-47

MARGIN RESERVED FOR BINDING

Please write plainly, with unfading ink. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

5/2/47

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

01174

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 18

1. PLACE OF DEATH:
County MONTGOMERY
City or town Bethesda 14, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, institution, or street address where death occurred: Suburban Hospital, Bethesda Md.
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ..... County .....
City or town 2801 Courtland Place N.W. Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME GREEN, ALZINA M.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	Widowed

6.(b) Name of husband or wife Franklin P. Green
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1853

8. AGE: Years	Months	Days	If less than one day
94	2	28	..... hrs. ..... min.

9. Birthplace Logansport, Indiana (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name David W. Conrad
13. Birthplace Indiana

MOTHER
14. Maiden name Catherine Onstatt
15. Birthplace Indiana

16. Informant T. W. Howard
Address 2801 Cortland Pl. N.W.

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 4/23/47 (month) (day) (year)
Cemetery or crematory Kennebunk, Maine
Location Maine

18. Funeral director W. Reuben Dunphrey
Address Bethesda, Maryland

19. 4/20 1947 Wm E Johns
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1947 at 4 20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947, to April 1947, and that I last saw h.r alive on April 1947

Immediate cause of death	DURATION
Bronchopneumonia right lower lobe	2 wks.
Due to Pulmonary edema	
Due to Myocardial decompensation	3 wks.
	3 wks.
Other conditions Thrombophlebitis, left femoral vein	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE Edward Wolff M.D.
M. D. or other
Address 3921 Ingomar St. Wash. D.C. Date signed 20 April '47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01175

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 DAYS
Hospital, institution, or street address where death occurred:
WASHINGTON SANITARIUM & HOSPITAL
How long in hospital or institution? 1 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 801 Greenwood Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs Rosa Ann Groot.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife: Deceased
6.(c) If alive, give age: ..... years
7. Birth date of deceased (mo., day, yr.): June 21, 1853

8. AGE: Years	Months	Days	If less than one day
93	10	9	..... hrs. ..... min.

9. Birthplace: Hamelia Co. (Town, county, and state)
10. Usual occupation: —
11. Industry or business: —

FATHER 12. Name	Mr. Benjamin Archer Traylor
FATHER 13. Birthplace	Informant not available.
MOTHER 14. Maiden name	
MOTHER 15. Birthplace	

16. Informant: WASHINGTON SANITARIUM HOSPITAL
Address: TAKOMA PARK, MARYLAND
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 3, 1947 (month) (day) (year)
Cemetery or crematory: Forestville Cemetery
Location: Richmond, Va.
18. Funeral director: J. Arthur Mallory
Address: 254 Carroll St. Takoma Park D.C.
19. May 1 1947 (Date rec'd by registrar) Registrar: J. Winn Dodd

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1947, at 6 A.M. P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23d 1947, to April 30 1947 and that I last saw her alive on April 30th 1947

Immediate cause of death	DURATION
Fractured left femur intertrochanteric	9 days.
Due to: fall at home —	
Due to: Senility —	years.
Other conditions: acute nephritis	2 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: 0 —
Date of op.:
Autopsy results: 0
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, ~~suicide, or homicide~~ Date of 4/22/47
Where did injury occur? Takoma Park (City or town) Md. (County) (State)
Injured at home, ~~farm, industry, public place (where?)~~
Means of injury fall — Injured at work? no —

23. SIGNATURE: John L. Brownsberger - M.D. (M. D. or other)
Address: Takoma Park — Date signed: 4/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01176

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~How long~~ street address where death occurred:
713 Boundry Ave.,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 713 Boundry Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: E'Pamnandus Grubbs

3.(b) Social Security Number: 579-10-2951

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband ~~XXX~~ Mary E.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 12th. 1876

8. AGE: Years	Months	Days	If less than one day
70	7	29	..... hrs. ..... min.

9. Birthplace: Upperville, Va.
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business

FATHER 12. Name: J. T. Grubbs
13. Birthplace: Virginia

MOTHER 14. Maiden name: Annie E. Anderson
15. Birthplace: Virginia

16. Informant: Mrs. Mary E. Grubbs
Address: 713 Boundry Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-14-47 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland, Pr. Geo's Co., Md.

18. Funeral director: Warner E. Pumphrey
Address: Silver Spring, Md.

19. 4 mo 17 19 ..... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11 1947 at 6:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18 1947 to April 11 1947
and that I last saw him alive on April 11 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	36 hrs.
Due to: Arterial Hypertension	Several years
Due to:	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results: Not done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Lee B. Snow M.D.
M. D. or other
Address: 914 Sligo Ave. Silver Spring, Md. Date signed 4-11-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

01177

CERTIFICATE OF DEATH

Reg. Dist. No. 4-14

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
410 Hillmoor Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 410 Hillmoor Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MRS. MABEL F. HAFLE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Charles William
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 30th. 1880

8. AGE: Years	Months	Days	If less than one day
66	5	19	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

MOTHER FATHER
12. Name: William E. Garner
13. Birthplace: Virginia
MOTHER
14. Maiden name: Jennie Weaver
15. Birthplace: Virginia

16. Informant: Mr. Charles W. Hafle
Address: 410 Hillmoor Dr.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-21-1947 (month) (day) (year)
Cemetery or crematory: Glenwood
Location: Washington, D. C.

18. Funeral director: Wanna E. Pumphrey
Address: Silver Spring, Md.

19. April 19 1947 (Date rec'd by registrar) Josephine M. Schaffe (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1947, at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1946, to April 19 1947 and that I last saw h er alive on April 8 1947

	DURATION
Immediate cause of death: Carcinomatosis	? 18 Mos.
Due to: Adeno Carcinoma of Colon	?
Due to:	
Other conditions: Diabetes Mellitus	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation: Adeno Carcinoma of Colon
Liver Metastasis
Date of op. May 13, 1946

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Merrill M. Cross M.D. M. D. or other
Address: 8512 Georgia ave Silver Spring, Md. Date signed 4/19/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

01178

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4832 Leland St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mr. George Washington Hewison

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Jane Hewison
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 14, 1872

8. AGE: Years 75 | Months 3 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace: New York, New York
(Town, county, and state)

10. Usual occupation: Accountant

11. Industry or business

FATHER
12. Name: Charles Hewison
13. Birthplace: New York

MOTHER
14. Maiden name: Charlotte Gillette
15. Birthplace: New York

16. Informant: Mrs. Arthur Dowell
Address: 4832 Leland St., Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/18/47 (month) (day) (year)
Cemetery or crematory: Rock Creek Cemetery
Location: Washington, D. C.

18. Funeral director: W. Reuben Humphrey
Address: 7557 Wisconsin Ave., Bethesda, Md.

19. 4/17/47 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16, 1947 19..... at 4:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9, 1947 to April 16, 1947 and that I last saw him alive on April 15, 1947

Immediate cause of death	DURATION
Congestive Heart Failure	24 hrs.
Due to: Cardio-vascular renal disease	5 yrs.
Due to:	
Other conditions: Cholelithiasis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Sidney L. Barnard M.D.
M. D. or other
Address: 3921 Livingston St. Date signed 4/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1523

1. PLACE OF DEATH:
County: Montgomery
City or town: Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital Inc.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R# 2 - Box 92
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Katherine Hoy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Mr. Edward J. Hoy
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): September 28, 1894

8. AGE: Years: 52 Months: 6 Days: 3 If less than one day: ____ hrs. ____ min.

9. Birthplace: Indianapolis, Indiana
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER
12. Name: August Woersdorfer
13. Birthplace: Germany

MOTHER
14. Maiden name: Augusta Jones
15. Birthplace: Germany

16. Informant: Hospital records
Address: Olney - Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 4 1947 (month) (day) (year)
Cemetery or crematory: Rock Creek Cemetery
Location: Washington - D C

18. Funeral director: Edward E Pumphrey
Address: Silver Spring - Md.

19. 4-4-1947 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/1/1947 at 11:29 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/11/1943 to 4/1/1947 and that I last saw h.. alive on 4/1/1947

Immediate cause of death	DURATION
Uraemia	10 days
Due to: Chronic Interstitial Nephritis	5
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Sandy Spring Md. Date signed: 4/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-D)

CERTIFICATE OF DEATH

01179

Reg. Diat. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Spencerville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Spencerville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Laura V Jackson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	C	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1, 1885

8. AGE: Years 62 Months Days If less than one day hrs. min.

9. Birthplace Spencerville, Md (Town, county, and state)

10. Usual occupation House keeper.

11. Industry or business

FATHER
12. Name Hamilton Johnson
13. Birthplace Md

MOTHER
14. Maiden name Sarah Tyler
15. Birthplace Md.

16. Informant Mrs. Hester Hackley (daughter)
Address Spencerville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3, 1947 (month) (day) (year)
Cemetery or crematory Rural Oak,
Location Spencerville, Md.

18. Funeral director R. L. Snyder
Address Rockville, Md.

19. May 3 1947 (Date rec'd by registrar) Josephine M Schaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1947 at 10:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7 1946 to April 30 1947 and that I last saw h alive on April 29 1947

Immediate cause of death	DURATION
Carcinomatosis	
Due to Airhaus Carcinoma of Rectum	
Due to	
Other conditions Typoid	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma Rectum involving Uterus, Ureter, + Bladder Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Webster Sewell, M.D.
M. D. or other
Address Norbeck, Md. Date signed 5-2-47

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

01180

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County: Washington

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No. 210 Brooks Court N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: 2nd WW ✓

3.(a) FULL NAME: JACKSON, Richard Levan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col,	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2 August 1921

8. AGE: Years	Months	Days	If less than one day
25	8	8	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: The Pullman Company

11. Industry or business: Union Station, Wash., D.C.

FATHER
12. Name: Levan Jackson
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden name: Carrie Newton
15. Birthplace: Va.

16. Informant: Mo: Mrs. Carrie Jackson
Address: 210 Brooks Court, N. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 4-15-47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: W. ERNEST JARVIS

Address: 1132 U St., N. W., Wash., D.C.

19. 4-10 (Date rec'd by registrar) 19 47 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 April 19 47, at 5:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 March 19 47, to 10 April 19 47 and that I last saw h..im alive on 10 April 19 47

	DURATION
Immediate cause of death: Hemorrhage, Cerebral	6 hours
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Hemorrhage, Cerebral (Gross findings)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. A. DINSMORE, Lt. Cdr. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 4-10-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

4/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

01181

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:
County: Montgomery
City or town: Colesville md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Monty
City or town: Colesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War # II

3.(a) FULL NAME: Benjamin H. Johnson

3.(b) Social Security Number: 577-14-9608

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 12 1919

8. AGE: Years 27 | Months 10 | Days 27 | If less than one day: hrs. min.

9. Birthplace: Colesville, Monty. Md.
(Town, county, and state)

10. Usual occupation: Truck driver

11. Industry or business

FATHER
12. Name: Charles Johnson (deceased)
13. Birthplace: maryland

MOTHER
14. Maiden name: Jennie Jackson
15. Birthplace: maryland

16. Informant: Jennie Johnson (mother)
Address: Silver Springs, md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 12, 1947 (month) (day) (year)
Cemetery or crematory: Good Hope
Location: Colesville, Maryland

18. Funeral director: R. L. Snowden
Address: Rockville, Md.

19. Apr 12 (Date rec'd by registrar) 1947 Josephine M. Scheele Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9 19 47 at 9:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec Med Exam 19 to care 19
and that I last saw h alive on 18

Immediate cause of death	DURATION
Inter Thoracic	died
hemorrhage	suddenly
Due to: gun shot wound	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results: same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: homicide Date of 4-9-47
Where did injury occur? Colesville (City or town) monty (County) md (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Broschart M.D.
Dep. Med. Exam. M. D. or other
Address: Gaithersburg md Date signed: 4-10-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01182

Reg. Dist. No. 7-14

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
708 Silgo Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penna. County: Warren
City or town: Warren
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 212 Onondaga Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: X

3.(a) FULL NAME: FREDERICA A JOHNSON

3.(b) Social Security Number: X

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	widowed

6.(b) Name of husband or wife: Andrew D.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 20th. 1868

8. AGE: Years	Months	Days	If less than one day
79	2	24	hrs. min.

9. Birthplace: Denmark (Town, county, and state)
10. Usual occupation: Retired Housewife
11. Industry or business

FATHER
12. Name: Unknown Larsen
13. Birthplace: Denmark

MOTHER
14. Maiden name: Unknown
15. Birthplace: Denmark

16. Informant: Mrs. Herbert R. Weston
Address: 906 Sligo Ave.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 4-14-1947 (month) (day) (year)
Cemetery or crematory: Oakland,
Location: Warren, Warren Co., Penna.
18. Funeral director: Warner E. Pumphrey
Address: Silver Spring, Md.

19. Apr. 14 19 47 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-14 19 47 at 4:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-1-1940 to 4-14-1947 and that I last saw her alive on 4-12-1947

Immediate cause of death	OURATION
Coronary occlusion	2 days
Due to Coronary sclerosis	10 yrs.
Due to generalized arterio-sclerosis	10 yrs.
Other conditions General cachexia	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M. Schaeffer M.D. M. D. or other
Address: 800 Woodbury Dr. Silver Spring, Md. Date signed: 4/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01183

CERTIFICATE OF DEATH

Reg. Dist. No. 217

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Brinklow MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 65 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Brinklow MD
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) no
2.(a) If veteran, name war

3.(a) FULL NAME: Isabel B. Jones

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Chas Scott Jones
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 2. 1871

8. AGE: Years	Months	Days	If less than one day
75	4	24	..... hrs. ..... min.

9. Birthplace: Brighton MD.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER 12. Name: Frederick T Browne
13. Birthplace: Maryland

MOTHER 14. Maiden name: Ann. M. Worrel
15. Birthplace: Maryland

16. Informant: Elizabeth B. Jones
Address: Brinklow MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29. 1947 (month) (day) (year)
Cemetery or crematory: St. Johns
Location: Olney MD.

18. Funeral director: Roy W. Barber
Address: Laytonsville, MD.

19. 4-28-1947 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: apr 26 - 1947 at 11 20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 - 1947, to apr 26 1947 and that I last saw her alive on apr 26 - 1947

Immediate cause of death	DURATION
Cardio Vascular disease	2 yrs.
Due to Chr Arterio sclerosis	2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Chas E Tumblesson M. D.
Address: Sandy Spring Md Date signed 4/29/1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (133-a)

01184

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Suburban Hospital.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2906 Nichols Ave S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Emma E Joy. (Mrs)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	M.

6.(b) Name of husband or wife James E Joy.

6.(c) If alive, give age Dec. years

7. Birth date of deceased (mo., day, yr.) Dec. 7. 1867

8. AGE:

Years	Months	Days	If less than one day
79	4	10	hrs. min.

9. Birthplace Hartford Co. Md.
(Town, county, and state)

10. Usual occupation None.

11. Industry or business

FATHER
12. Name Mr Alfred Allen.
13. Birthplace Eastern Shore Maryland.

MOTHER
14. Maiden name Hendrix.
15. Birthplace Maryland

16. Informant Emma C. Joyce.
Address 2009 - Kingle Rd N.W. Washington D.C.

17. Burial, cremation, or removal. Which? Burial. Date thereof April 15, 1947 (month) (day) (year)

Cemetery or crematory Rock Creek S.S.E. Cemetery

Location Chevy Chase, Md (Montgomery Co.)

18. Funeral director Brown & Doyle

Address 5406 Connecticut Ave N.W. DC

19. 4/16 1947 (Date rec'd by registrar) Mr E Jales Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1947, at 12 50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/27 1947 to 4/15 1947 and that I last saw h alive on 2/27 1947

	DURATION
Immediate cause of death Left hydronephrosis with complete obstruction, ureter Kidney - unknown etiology	acute 10 days
Due to Diabetes mellitus	unknown
Due to Arteriosclerosis, sigmoid	unknown
Other conditions Senility & obesity	years

(Include pregnancy within 3 months of death)

Major findings of operations Nearly later thigh wound Buttock area L. Kidney Date of op. 4/12/47

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None

Means of injury Injured at work?

23. SIGNATURE L O Bl Wardrop M.D. M. D. or other

Address 943 Bonifant St. Date signed 4/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Ek J. Stieglitz
1726 - Eng. Mus

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-a)

CERTIFICATE OF DEATH

01185

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since 4-7-47
Hospital, institution, or street address where death occurred: Suburban Hosp., 8600 Old Georgetown Rd. Bethesda Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County
City or town Kensington (If outside city or town limits, write RURAL and give nearest town)
Street No. 13 Decatur St. (If rural, give LOCATION)
(a) If veteran, name war

3. (a) FULL NAME Mr Alva R. Kidwell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	M

6.(b) Name of husband or wife Rose C. Kidwell
6.(c) If alive, give age ...... years
7. Birth date of deceased (mo., day, yr.) June 7, 1898

8. AGE: Years	Months	Days	If less than one day
48	10	2	...hrs. ...min.

9. Birthplace Mersville Va. (Town, county, and state)
10. Usual occupation ? (Unemployed)
11. Industry or business
FATHER 12. Name Willard Kidwell
13. Birthplace Mersville, Virginia
MOTHER 14. Maiden name Dora Harding
15. Birthplace Mersville, Virginia
16. Informant Rose C. Kidwell
Address 15 Decatur St - Kens.
17. Burial (Burial, cremation, or removal, Which?) Date thereof 4/13/47 (month) (day) (year)
Cemetery or crematory Hillsboro
Location Va
19. Funeral director W. W. Chambers Co.
Address 1400 - Chapin St. N.W.
19. 4/9 (Date rec'd by registrar) 1947 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-9-47 1947, at 2:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...... 19.., to ...... 19..
and that I last saw h.. alive on ...... 19..

Cause	DURATION
Immediate cause of death Congestive Heart failure.	2 wks
Due to Coronary Occlusion c myocardial infarction	6 mos
Due to	
Other conditions Aortic Stenosis - Chronic [illegible] Congestive liver [illegible] & spleen & pulmonary [illegible] (Include pregnancy within 3 months of death)	2 wks

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Andrew Grandoni MD M. D. or other
Address 2025 Eye St NW Wash DC Date signed 4/9/47

VS A15 9-45-15M

01186

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
9122 Kimes Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9122 Kimes St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Virgil Thomas Kilgore

3.(b) Social Security Number: 510-09-7552

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Eva W.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 12th. 1889

8. AGE: Years	Months	Days	If less than one day
57	18	15	..... hrs. ..... min.

9. Birthplace: El Dorado, Kansas
(Town, county, and state)
10. Usual occupation: Bank Clerk
11. Industry or business
FATHER 12. Name: William E. Kilgore
13. Birthplace: Scott Co., Va.
MOTHER 14. Maiden name: Mary E. Collier
15. Birthplace: Kentucky
16. Informant: Mrs. Eva. W. Kilgore,
Address: 9122 Kilgore St., Silver Spring
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-30-1947 (month) (day) (year)
Cemetery or crematory: Rock Creek
Location: Washington, D. C.
18. Funeral director: Warner E Pumphrey
Address: Silver Spring, Md.
19. April 28 19 47 Josephine M Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27 1947 at 10:40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Coronary occlusion	Few minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Broschart M. D.
Dep. Med. Exam. M. D. or other
Address: Gaithersburg Md Date signed 4-28-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

01187

Reg. Diat. No. 21

1. PLACE OF DEATH:

County Montgomery

City or town Cedar Knoll rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rural Cedar Knoll

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thomas D King

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Mal	W	Married

6.(b) Name of husband or wife Della Hilton King

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Aug 14 - 1867

8. AGE: Years 79 | Months 7 | Days 25 | If less than one day ... hrs. ... min.

9. Birthplace maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farm

FATHER 12. Name Charly King

13. Birthplace Maryland

MOTHER 14. Maiden name Harriet Brewer

15. Birthplace Maryland

16. Informant Mrs Della King

Address Germantown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 10 1947 (month) (day) (year)

Cemetery or crematory Montain View

Location Poolesville md

18. Funeral director Roy W. Barber

Address Laytonsville Md

19. April 8 1947 (Date rec'd by registrar) Della V. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1947 at 4:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1945 to April 6 1947

and that I last saw him alive on April 6 1947

Immediate cause of death	DURATION
Arterio-sclerotic heart disease,	15 yrs
Due to Generalized arterio-sclerosis,	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M McKenbree Dow M.D. M.D. or other

Address Damascus Md Date signed 4-8-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01188

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, institution, or street address where death occurred: 260 Maple Avenue, Takoma Park, Md.

How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Dist of Col. County: (N.W.)

City or town: Washington, D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2706 36th Street

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: Mildred Joyner Kirkpatrick

3.(b) Social Security Number:

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 5, 1859

8. AGE: Years: 88 Months: 2 Days: 23 If less than one day: hrs. min.

9. Birthplace: Amherst Amherst, Virginia (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER 12. Name: Samuel Kirkpatrick

FATHER 13. Birthplace: Amherst, Virginia

MOTHER 14. Maiden name: Anna Watts

MOTHER 15. Birthplace: Amherst, Virginia

16. Informant: Mrs. Minnie B. Cooley

Address: 2706 36th St. N.W. Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 30 1947 (month) (day) (year)

Cemetery or crematory: Riverview Cemetery,

Location: Strasburg, Virginia

18. Funeral director: Stover Funeral Home.

Address: Strasburg, Virginia.

19. Apr 29 47 (Date rec'd by registrar) J. Nelson Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28, 1947, at 11:58 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15, 1947, to April 28, 1947

and that I last saw her alive on April 26, 1947

Immediate cause of death	DURATION
Heart Failure	1 week.
Due to: Carcinoma of Left Breast	2 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Walter W. Gibson, M.D. M. D. or other

Address: Riverdale, Maryland Date signed: 4-29-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

01189

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 4-13-47

Hospital, institution, or street address where death occurred:
Suburban Hospital-8600 Old Georgetown Rd.

How long in hospital or institution? Since 4-13-47 Bethesda, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 27 Dietrich Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Kathryn Kittelson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Sam Kittelson

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Dec. 11, 1890

8. AGE: Years	Months	Days	If less than one day
56	4	4	...hrs. ...min.

9. Birthplace: Cavalier, North Dakota
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Wm. Jackson
13. Birthplace: Canada

MOTHER — 14. Maiden name: Margaret Shalane
15. Birthplace: Canada

16. Informant: Mr. Sam Kittelson
Address: Detroit Lakes, Minnesota

17. Shipment (Burial, cremation, or removal. Which?) Date thereof April 16, 1947 (month) (day) (year)

Cemetery or crematory: Oak Grove Cemetery

Location: Detroit Lakes, Minnesota

18. Funeral director: Wm Reuben Dumphrey

Address: Bethesda, Maryland

19. 4/16 19 47 Wm E Jones Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15, 1947, at 7:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/13/47 19.., to 4/15/47 19.. and that I last saw her alive on 4/13/47 19..

Immediate cause of death	DURATION
(a) Hemorrhage, Cerebral, Left; acute; Senile	48 hrs
(b)	
Due to: (a) Arteriosclerosis; generalized; moderate	
(c) Hypertension; Arterial	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: N.M.

Date of op.

Autopsy results: N.M.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)...

Means of injury... Injured at work?

23. SIGNATURE: Samuel Allen M.D.
M. D. or other

Address: Kensington Md. Date signed 4/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-L) X

CERTIFICATE OF DEATH

01190

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4041 7th St., N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: 1st WW ✓

3. (a) FULL NAME: LAUFER, August Frederick

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Sarah Laufer

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 7 August 1869

8. AGE: Years	Months	Days	If less than one day
77	8	2	..... hrs. ..... min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER
12. Name: Martin Laufer
13. Birthplace: Germany dec.

MOTHER
14. Maiden name: Mary Augaule
15. Birthplace: Germany dec.

16. Informant: Wife: Mrs. Sarah Laufer
Address: 4041 7th St., N.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 4-11-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS & S.

Address: 1400 Chapin St., N.W., Wash., D.C.

19. April 9 1947 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9 1947, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 March 1947 to 9 April 1947 and that I last saw him alive on 9 April 1947

	DURATION
Immediate cause of death: Intestinal obstruction	1 month
Due to: Melanosarcoma of rectum, metastatic	2 years
Due to: to liver & colon.	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... (Date of op.)

Autopsy? Pathologic findings: Melanosarcoma of rectum, colon and liver.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: R. N. GRANT, Cdr. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 4-9-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

4/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-a)

CERTIFICATE OF DEATH

01191

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 6 days

Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital

How long in hospital or institution? 1 month 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. F.C. County:

City or town: Washington 20
(If outside city or town limits, write RURAL and give nearest town)

Street No. 60 76 Allentown Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Lewis, Miss Alice Agnes

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 2, 1874

8. AGE: Years	Months	Days	If less than one day
72	3	18	hrs. min.

9. Birthplace: D.C.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Christopher Lewis
13. Birthplace: Va.

MOTHER
14. Maiden name: Mary Stewart
15. Birthplace: Va.

16. Informant: Washington Sanitarium and Hosp.
Address: Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/21/47 (month) (day) (year)

Cemetery or crematory: Congressional

Location: Wash. D.C.

18. Funeral director: J. W. Lee Sons Co.

Address: 360-4 St. N.E. Washington D.C.

19. Apr 19 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 26 1939 to April 19 1947 and that I last saw h[illegible] alive on April 18 1947

Immediate cause of death	DURATION
uremia	1 month
Due to: Chr. nephritis	2 years
Due to: arteriosclerotic cardiovascular disease	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Henry G. Hadley M.D. M. D. or other

Address: 625 14th St. N.W. Date signed: Apr 19 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-d) X

01192

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
WASHINGTON SANITARIUM
How long in hospital or institution? 18 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: MONTGOMERY
City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 102 PARK AVE
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HELEN LONGACRE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	SINGLE

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 17, 1880.

8. AGE: Years: 66 | Months: 3 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: Lehigh Co. Pennsylvania (Town, county, and state)

10. Usual occupation: Mailing Clerk

11. Industry or business: Review and Herald Publishing Assoc

FATHER 12. Name: Henry W. Longacre
13. Birthplace: Pennsylvania

MOTHER 14. Maiden name: Elizabeth Small
15. Birthplace: Pennsylvania

16. Informant: Records - Washington San. & Hosp.
Address: Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 15, 1947 (month) (day) (year)
Cemetery or crematory: Old Mennonite Cemetery
Location: Steinsburg, Penna.

18. Funeral director: Walter E. Talbert.
Address: 29 Carroll St. N.W. Takoma Park, D.C.

19. April 14, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13, 1947, at 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar. 26, 1947, to Apr. 13, 1947 and that I last saw h[illegible] alive on April 12, 1947

Immediate cause of death	DURATION
Carcinoma of rectum -	1 yr ?
Due to: Ileus	10 days
Due to:	??
Other conditions: Nephritis & Pyelitis	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of rectum abdominal adhesions. Date of op.: Mar 28 1947 Apr 3 1947 Apr 7 "

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Leon N. Calvert M.D. M. D. or other
Address: 7894 Eastern Ave S.S. Md. Date signed: 4-13-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

01193

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: Kensington (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mos
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Montg.
City or town: Kensington (If outside city or town limits, write RURAL and give nearest town)
Street No. 3400 Plyers Mill Rd (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HENRY KING LOVE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife: Josephine Chase
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 1, 1862

8. AGE: Years 84 | Months 9 | Days 26 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Keokuk, Iowa (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: U. S. Army

FATHER
12. Name: James M Love
13. Birthplace: Fairfax Va

MOTHER
14. Maiden name: Mary Thomasson
15. Birthplace: Louisville, Ky

16. Informant: Mrs Von Steinmer-Boeckl
Address: 3400 Plyers Mill Rd

17. Cremation (Burial, cremation, or removal) Which?) Date thereof 4-29-47 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Lurtland, Md

18. Funeral director: Joseph Gawler's Sons
Address: 1756 Pa Ave NW

19. April 27 1947 (Date rec'd by registrar) Josephine Van Schaeffer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27 1947, at 2.4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 11 1947 to April 27 1947 and that I last saw h... alive on April 26 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	—
Due to	
Due to	
Other conditions: Generalized arteriosclerosis (Include pregnancy within 3 months of death)	

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: J. Marion Barnhart M.D. M. D. or other
Address: Silver Spring Date signed 4/27/47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of age is shown on

01194

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

FILM No. G 11 MAY 21 1947

Reg. Diat. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Olney
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 weeks
Hospital, Institution, or street address where death occurred:
Montgomery Co. Gen. Hospital
How long in hospital or institution? 6 weeks S.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1024 Paul Drive,
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Harriett Moguder

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife John H. Moguder
6.(c) If alive, give age 58 years
7. Birth date of deceased (mo., day, yr.) 7/21/1889

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
47 49	9	5		

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual occupation H.W.
11. Industry or business
FATHER 12. Name Edw. S. Ryan
13. Birthplace Va.
MOTHER 14. Maiden name Mary E. Ward
15. Birthplace Md.
16. Informant John H. Moguder
Address Rockville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/28/47 (month) (day) (year)
Cemetery or crematory Darnestown Church Cemetery
Location Darnestown, Maryland
18. Funeral director Wm. Louden Pumphrey
Address Rockville, Maryland
19. 4-28 1947 (Date rec'd by registrar) Gertrude B. Lawlor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/26/1947 at 7:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/1/1943 to 4/26/1947 and that I last saw h[er] alive on 4/26/1947

	DURATION
Immediate cause of death: Coronary Thrombosis	4 days
Due to: Chronic Interstitial Nephritis	years
Due to: Arteriosclerosis & hypertension	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: None Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Laytonsville, Md. Date signed 4/26/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M The correct age

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-c)

CERTIFICATE OF DEATH

MV 01195

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Montg, Co,
City or town: Germantown, (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montg
City or town: Germantown, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles Curtis Mann

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): March 25th 1899

8. AGE:	Years	Months	Days	If less than one day
1899	48	0	14	...hrs. ...min.

9. Birthplace: Lovettsville, Va, (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: "

FATHER
12. Name: John W. Mann
13. Birthplace: Va,

MOTHER
14. Maiden name: Exie Hough
15. Birthplace: Va,

16. Informant: Exie Hough Mann
Address: Derwood, Md, R F D,

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/22/47 (month) (day) (year)
Cemetery or crematory: Luthern Cemetery
Location: Lovettsville, Va,

18. Funeral director: Ernest C, Gartner
Address: Gaithersburg. Md,

19. April 21 1947 Alinda S. Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/19/ 1947 at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post mortem to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Intra abdominal hemorrhage	Instantaneous
Due to: Ruptured liver	
Due to: Cerebral concussion, Intra cranial hemmorhage	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: Ruptured liver Intra cranial Hemmorhage

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 4/19/47
Where did injury occur? Middle Brook Montg Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Highway # 240
Means of injury: Hit by automobile Injured at work?

23. SIGNATURE: [signature] Cert. Path. M. D. or other
Address: Sandy Spring Md Date signed 4/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I)

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01196

(94a)

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County: Montgomery

City or town: Washington,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 237 B Street, S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: unknown ✓

3.(a) FULL NAME: MARKS, Walter Chapin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 9 March 1881

8. AGE: Years	Months	Days	If less than one day
66	1	15	..... hrs. ..... min.

9. Birthplace: Mo. (Town, county, and state)

10. Usual occupation: Government (retired)

11. Industry or business: Internal Revenue

FATHER
12. Name: William A. Marks dec.
13. Birthplace: Va.

MOTHER
14. Maiden name: Julia Alexandra dec.
15. Birthplace: Va.

16. Informant: Brother: Mr. Samuel Marks
Address: 237 Rainey Avenue, St. Augustine, Fla

17. burial (Burial, cremation, or removal. Which?) Date thereof: 4-28-47 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln

Location: Bladensburg, Md.

18. Funeral director: S. H. HINES L.F.D.

Address: 2901 14th St., N.W., Wash., D.C.

19. 4-25 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 April 19 47, at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 April 19 47, to 24 April 19 47 and that I last saw him alive on 24 April 19 47

Immediate cause of death	DURATION
Cardiac failure (Coronary Heart Disease)	94a
Due to: Hypertension; generalized heart failure; alidosis.	102
Due to: Multiple infarcts	666
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Provisional: Congestive Heart Failure & Bronchopneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: H. L. C. Stevens Lt(jg)(MC)USNR
H. L. C. STEVENS, Lt.(jg)(MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 4-25-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

5/5/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

01197

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS A15 9-45-15M

4/7 3/47

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months, 6 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 6 months, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3909 Kansas Avenue, Northwest
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I & II ✓

3.(a) FULL NAME

MARTIN Harry (n)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	Divorced

6.(b) Name of husband or wife: Mrs. Rose Martin

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 15, 1900

8. AGE: Years	Months	Days	If less than one day
47	0	2	hrs. min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business

FATHER

12. Name: Abraham Martin, Dec.

13. Birthplace: Pennsylvania

MOTHER

14. Maiden name: Sophia Green

15. Birthplace: Iowa

16. Informant: Mr. Samuel I. Fink

Address: 126 South 56th Street, Phila., Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-21-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: Sigmund Danzansky & Att

Address: 3501 14th St, NW, Washington, D. C.

19. (Date rec'd by registrar): april 18 1947 Registrar: mary charlotte smith

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 April 1947, at 1:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 11 1946, to 17 April 1947 and that I last saw him alive on 17 April 1947

Immediate cause of death	DURATION
Coronary occlusion	
Due to: A Possible embolus	
Due to: a Possible thrombus	
Other conditions: Intestinal obstruction; due to adhesions; not due to cancer. (Include pregnancy within 3 months of death) cwb R.	

Major findings of operations:

Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

W. B. Ford

23. SIGNATURE: W.B.FORD LT MC USN
M. D. or other

Address: U.S.Naval Hosp., Bethesda, Md. Date signed: 4-18-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(94a)

01198

Reg. Diat. No. 314

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 627 Gist Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anna Mayer

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband ~~or wife~~ Julius E. Mayer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr. 29, 1877

8. AGE: Years	Months	Days	If less than one day
69	11	24	..... hrs. ..... min.

9. Birthplace Allegheny (Pittsburg), Pa.
(Town, county, and state)

10. Usual occupation H-wife.

11. Industry or business

FATHER
12. Name Charles Hauch
13. Birthplace Pa.

MOTHER
14. Maiden name Julianna Pontius
15. Birthplace Pa.

16. Informant Julius E. Mayer
Address 627 Gist. Ave, Sil. Spg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 26 1947 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Pr. Geo Cy., Md.

18. Funeral director W.W. Chambers Co.

Address 1400 Chapin St. NW. Wash, DC

19. Apr. 23 (Date rec'd by registrar) 1947 Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23, 1947, at 9.50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 1945, to 4/23 1947.

and that I last saw h.. alive on 4/22 1947.

	DURATION
Immediate cause of death Coronary occlusion	48 hrs.
Due to: Generalized arterio-sclerosis	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE O.H. Duffey M.D. M. D. or other

Address 4200 - 9st N.W. Date signed 4/23/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

01199

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 58-2

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
U. S. NAVAL HOS. BETHESDA MD.
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1407 W.Va., Avenue, N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: 2nd WW ✓

3.(a) FULL NAME: Alexander Joseph MC ALISTER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 1, 1920

8. AGE: Years	Months	Days	If less than one day
26	8	3	hrs. min.

9. Birthplace: Florida
(Town, county, and state)

10. Usual occupation:
11. Industry or business: Government

FATHER
12. Name: Joseph McAlister
13. Birthplace: Ireland

MOTHER
14. Maiden name: Catherine Callozay
15. Birthplace: Scotland

16. Informant: Mother: Mrs. Catherine McAlister
Address: 1407 W.Va., Avenue, N.W., Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-8-47 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington Va.

18. Funeral director: T. H. HANLON
Address: 641 H. St. NW Wash, D. C.

19. 4-6 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 April 1947 at 4:35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 April 1947 to 5 April 1947 and that I last saw him alive on 5 April 1947

Immediate cause of death	DURATION
Acute Rheumatic Pericarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Acute & Chronic rheumatic heart disease, bronchopneumonia congestive heart failure & terminal
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. H. E. SMITH, Cdr. (MC) USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 4-5-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

4/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

01201

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
U.S.N.H. BETHESDA MD.
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1901 Columbia Road, N.W., Apt. 401,
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mary HUBBARD MC TWIGGAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	widowed

6.(b) Name of husband or wife:
11-25-1871 6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): November 25, 1871

8. AGE: Years	Months	Days	If less than one day
75	4	10	..... hrs. ..... min.

9. Birthplace: Ill.
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business

FATHER
12. Name: Frank Evans
13. Birthplace: New York

MOTHER
14. Maiden name: Adale Evans
15. Birthplace: New York

16. Informant: daughter: Mrs. Jeanette Butler
Address: 1901 Columbia Road, N.W., Wash., D.C., Apt. 401

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-8-47 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington Va.

18. Funeral director: Hines Funeral Directors
Address: 2901 14th St. NW WASH. D.C.

19. 4-5 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 April 1947, at 2:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31 March 1947 to 5 April 1947 and that I last saw her alive on 5 April 1947

Immediate cause of death: Cerebral hemorrhage into left internal capsule — DURATION

Due to: Hypertension, arterial, arteriosclerosis

Due to: cardiac hypertrophy, coronary sclerosis, old myocardial infarction, pulmonary congestion, and auricular fibrillation.

Other significant conditions contributing to death but not related to terminal disease conditions:
(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R. C. Parker
R. C. PARKER, Jr. Cdr. (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed 4-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

4/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (197)

CERTIFICATE OF DEATH

01202

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4708 N. Chelsea St.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: MARGARET ELIZABETH MILES

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Steven A.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 3, 1862

8. AGE: Years: 85 | Months: 0 | Days: 7 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Defiance, Ohio (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Thomas Conn
13. Birthplace: Belfast Ireland

MOTHER
14. Maiden name: Isabelle Taylor
15. Birthplace: Belfast Ireland

16. Informant: Mrs. Minnie B. Myers
Address: 4708 N. Chelsea St., Bethesda

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/14/47 (month) (day) (year)
Cemetery or crematory: Odd Fellows Cemetery
Location: Marengo, IOWA

18. Funeral director: Wm Reuben Pumphrey
Address: 7557 Wisconsin Ave., Bethesda, Md.

19. 4/11 19 47 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/10/47 19..... at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12 19 46 to April 10 19 47
and that I last saw h.e. alive on April 10 19 47

Immediate cause of death	DURATION
Bronchopneumonia	5 Days
Due to	
Due to	
Other conditions: Ruptured esophageal ulcer 4 months ago. Old age. (Include pregnancy within 3 months of death)	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Bruce L. Benjamin M.D. M. D. or other
Address: Bethesda, 14, Md. Date signed: 4/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63)

01203

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4856 Chevy Chase Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I.

3. (a) FULL NAME: William Robert Moffett

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Lizzie S. Moffett
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Nov 7, 1890

8. AGE: Years: 56 Months: 5 Days: 16 If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland. (Town, county, and state)
10. Usual occupation: U S Gov. Geo
11. Industry or business

FATHER
12. Name: Robert Moffett
13. Birthplace: Virginia

MOTHER
14. Maiden name: Elizabeth Johnson
15. Birthplace: Maryland.

16. Informant: Mrs. Lizzie S Moffett.
Address: 4856 Chevy Chase.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/25/47 (month) (day) (year)
Cemetery or crematory: Arlington Nat'l Cem.
Location: Arlington, Va.
18. Funeral director: The D. H. Bines Co
Address: 2401 14th St NW.

19. 4/23 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23 1947 at 5:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/23 1945 to 4/11 1947 and that I last saw h... alive on 4/11 1947

Immediate cause of death	DURATION
Hypertonic Heart disease	
Due to	
Due to	
Other conditions: cirrhosis of liver	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: I. L. Marks, M.D.
M. D. or other
Address: 4601 Leland St. Date signed 4/23/47

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

01204

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:
County: Montgomery
City or town: Clagettsville Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 57 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Clagettsville, Md. Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: NO

3.(a) FULL NAME: LeRoy Moxley

3.(b) Social Security Number: 219-20-4905

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Frances W. Moxley
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Aug. 29. 1889

8. AGE: Years	Months	Days	If less than one day
57	7	19	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Store

FATHER
12. Name: Robert Moxley
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Fannie A. Moxley
15. Birthplace: Maryland.

16. Informant: Frances W. Moxley
Address: Clagettsville. MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 20 1947 (month) (day) (year)
Cemetery or crematory: Montgomery
Location: Clagettsville. Md.

18. Funeral director: Roy W. Barber
Address: Laytonsville, Md.

19. April 20 1947 (Date rec'd by registrar) Della N. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18 1947, at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19, 1943 to April 18, 1947 and that I last saw h[illegible] alive on April 18 1947

Immediate cause of death	DURATION
Coronary occlusion	5 days
Due to: Arteriosclerotic cardiovascular disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James P. Kerr M.D. M. D. or other
Address: Damascus, Md. Date signed: 4/19/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

01200

Reg. Diat. No. 216

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since March 31, 1947

Hospital, institution, or street address where death occurred:
Suburban Hospital - 8600 Old Georgetown Rd.

How long in hospital or institution? Since Mar. 31, 1947 Bethesda Md.,

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State ..... County .....

City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 720 Varnum St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Mrs Martha A. Muller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) ~~Single, married~~, widowed, ~~or divorced~~
F	W	

6.(b) Name of husband or wife Christian Muller (Dec)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 8, 1886

8. AGE: Years	Months	Days	If less than one day
60	9	21	..... hrs. ..... min.

8. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Michal Heddermam

13. Birthplace ? Ireland

MOTHER 14. Maiden name Mary Drury

15. Birthplace ? Virginia

18. Informant Hosp. Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 29-47 (month) (day) (year)

Cemetery or crematory Removal. Wash D.C.

Location Mt Olivet Cem.

18. Funeral director Francis J. Collins

Address 3821-14 St. NW. D.C.

19. 4/29 19 47 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-29-1947 19 25 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/31 19 47 to 4/29 19 47 and that I last saw h~~e~~r alive on 4/28 19 47

Immediate cause of death	DURATION
Coronary thrombosis	4 wks
Due to Coronary sclerosis	1 year
Due to Diabetes mellitus	1 year
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Daniel B. Washington M.D.
M. D. or other

Address 6234 2a Ave NW Date signed 4/28/47

9654

01205

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

Reg. Diat. No. 26

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Couoty:

City or town: Washington D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4722 - 46th St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Sue Lucille Murphy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife: William T.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov - 23, 1890.

8. AGE:

Years	Months	Days	If less than one day
56	4	15	hrs. min.

9. Birthplace: Elmira, N. Y. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: Augustus Greener

13. Birthplace: Elmira N.Y.

MOTHER

14. Maiden name: Anna Hollbraun

15. Birthplace: Elmira, N.Y.

16. Informant: Hosp. Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April-10-1947 (month) (day) (year)

Cemetery or crematory: Rockville Cemetery

Location: Rockville Maryland

18. Funeral director: The S.P. Hines Co.

Address: 2901 - 14th St. N. W., Wash. D.C.

19. 4 8 (Date rec'd by registrar) 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7, 1947 at 7 35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1946, to April 1947

and that I last saw her alive on April 1947

Immediate cause of death	DURATION
Hemiplegia Left	2 wks
Due to: Cerebral arterio	1 yr
Due to: Diabetes Mellitus	10 yrs
Other conditions: Hypertension	15 yrs

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: Macroscopic not obtained

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W B Murphy MD (M. D. or other)

Address: Rockville Md Date signed: April 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

01206

Reg. Dist. No. 212

1. PLACE OF DEATH:

County Montgomery

City or town Boyd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 63 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Boyd

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Henry Norris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Nonie D. Norris

6.(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) June-6-1863

8. AGE: Years 83 | Months 10 | Days 22 | If less than one day ... hrs. ... min.

9. Birthplace Poolesville, Montg. Co. Md (Town, county, and state)

10. Usual occupation Retired U.S. Gov.

11. Industry or business Post Office

FATHER 12. Name Josiah Norris

FATHER 13. Birthplace Maryland.

MOTHER 14. Maiden name Margaret Lowe

MOTHER 15. Birthplace Maryland.

16. Informant Mrs. James H. Norris

Address Boyd, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 30-47 (month) (day) (year)

Cemetery or crematory Monocacy

Location Beallsville, Md

18. Funeral director William B. Hilton

Address Barnesville, Md

19. April 29 1947 (Date rec'd by registrar) Mrs. C. C. Nilton By Mrs. C.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28. 1947, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1943 to April 28. 1947 and that I last saw h.im alive on April 27 1947

	DURATION
Immediate cause of death Acute Coronary Thrombosis	12 hours
Due to Chronic Myocarditis	
Due to Rheumatic Fever (As a child)	6 Wks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE Upton D. Mouse M.D. M. D. or other

Address Dawsonville Md. Date signed 4/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

01207

2411 N. Charles St., Baltimore (25-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Iowa County:

City or town: Chariton
(If outside city or town limits, write RURAL and give nearest town)

Street No. 902 Penick Avenue
(If rurol, give LOCATION)

2.(a) If veteran, name war: 2nd WW

3.(a) FULL NAME: ORR, John Parley, Gunner USN Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 20, 1912

8. AGE: Years	Months	Days	If less than one day
34	9	25	hrs. min.

9. Birthplace: Ohio
(Town, county, and state)

10. Usual occupation: Gunner

11. Industry or business: US Navy

FATHER
12. Name: John Parley ORR, Sr.
13. Birthplace:

MOTHER
14. Maiden name: Stella ?
15. Birthplace: unknown

16. Informant: Mother: Mrs. Stella Maxwell

Address: 1516 Main St., Davenport, Iowa

17. removal (Burial, cremation, or removal. Which?) Date thereof 4-17-47 (month) (day) (year)

Cemetery or crematory:

Location: Chariton, Iowa

18. Funeral director: W. W. CHAMBERS

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 4-16 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 April 1947 at 10:45AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 April 1947, to 15 April 1947 and that I last saw h... im alive on 15 April 1947

	DURATION
Immediate cause of death: Acute Hepatic insufficiency	5 days
Due to: acute Hepatitis	8 days
Due to: unknown	
Other conditions: Sub-acute yellow atrophy of liver?	unknown

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: Acute hepatitis with cholemia and terminal bronchopneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Gunther
J. GUNTHER, Cdr. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 4-16-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

4/23/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

01208

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
805 MAPLE AVE

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2719 - Ontario Road
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: ANNIE OWEN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	widow

6.(b) Name of husband or wife: W. O. OWEN

7. Birth date of deceased (mo., day, yr.): ~~February 18 1858~~ February 18, 1858 6.(c) If alive, give age: — years

8. AGE:

Years	Months	Days	If less than one day
89			hrs. min.

9. Birthplace: LYNCHBURG - VA.
(Town, county, and state)

10. Usual occupation: NONE

11. Industry or business:

FATHER
12. Name: JAMES CHALMERS
13. Birthplace: VA.

MOTHER
14. Maiden name: Fannie Saunders
15. Birthplace: Va.

16. Informant: Una OWEN
Address: 2719 - Ontario Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-16-1947 (month) (day) (year)

Cemetery or crematory: arlington nat.

Location: arlington Va.

18. Funeral director: Joel Gawler & Son

Address: 1756 Penna ave. N.W. Washington D.C.

19. 4-15 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15, 1947, at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 1947, to April 15 1947 and that I last saw her alive on April 15 1947

Immediate cause of death	DURATION
Arteriosclerotic heart disease	2-3 yr.
Due to: Chronic myocarditis.	
Due to: with failure	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C P Ryland M D
M. D. or other

Address: 4901 Mass Ave NW Wash 16 D C Date signed: 4-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

01209

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1128 6th St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: Sp. American War ✓

3.(a) FULL NAME: PARHAM, Edward Derwyn

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 22, 1873

8. AGE: Years	Months	Days	If less than one day
74	2	16	hrs. min.

9. Birthplace: Richmond, Va.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Eramus Parham
13. Birthplace: Va.

MOTHER
14. Maiden name: Martha ?
15. Birthplace: Va.

16. Informant: nephew: Mr. Percy V. Mason
Address: 1128 6th St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 4-11-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Malvan & Schey, Inc. W.E.A.

Address: 424 R. St., N.W., Wash., D.C.

19. 4-8 19 47 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8 1947, at 6:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 April 1947, to 8 April 1947, and that I last saw h... im... alive on 8 April 1947.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	6 days
Due to: Arterio-sclerosis	Indef.
Due to:	
Other conditions: Chronic Myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. H. McMILLAN, Capt. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 4-8-47

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

4/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

01210

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, Institution, or street address where death occurred:
52 Beech Avenue,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 52 Beech Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME POORE, WILLIAM R.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Katherine L.
6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) September 14, 1874

8. AGE: Years	Months	Days	If less than one day
72	6	24	hrs. min.

9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name John W. Poore
13. Birthplace Washington, D. C.

MOTHER
14. Maiden name Mary Allen
15. Birthplace Washington, D. C.

16. Informant Mrs. Katherine L. Poore
Address 52 Beech Ave., Bethesda, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/11/47 (month) (day) (year)
Cemetery or crematory St. Marys Catholic Cemetery
Location Rockville, Maryland
18. Funeral director Wm Reuben Thompkins
Address 7557 Wis. Ave. Bethesda, Maryland

19. 4/9 1947 Jm E Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1947 at 4:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 13 1945 to Apr. 8 1947 and that I last saw alive on Feby. 28 1947

Immediate cause of death	DURATION
Cardiac Exhaustion	
Due to: Senile Dementia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. A. A. Dunn M. D. or other
Address Bethesda Md. Date signed Apr 8 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-d)

CERTIFICATE OF DEATH

01211

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Glenelg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Florence Powell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married.

6.(b) Name of husband or wife Edward Powell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 30, 1902

8. AGE: Years	Months	Days	If less than one day
44	10	4	..... hrs. ..... min.

9. Birthplace Howard Co. Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name William Young

13. Birthplace Howard Co. Md.

MOTHER 14. Maiden name Margaret Porter

15. Birthplace Howard Co. Md.

16. Informant Hospital Records -

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-7-47 (month) (day) (year)

Cemetery or crematory Bushy Park

Location Glenwood Md

16. Funeral director P.C. Higinbothom

Address Ellicott City Md

19. 4-4- 1947 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1947, at 1:15 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 1946, to April 4 1947

and that I last saw her alive on April 4 1947

Immediate cause of death	DURATION
Uremia	2 days
Due to Hypertensive cardiovascular renal disease	1 year
Due to	
Other conditions Inactive arthritis	? yrs

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles S. Whitaker, M.D. M. D. or other

Address Clarksville, Md Date signed 4/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1524

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1769 Willard St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: 1st WW

3.(a) FULL NAME: REED, Walter Lemuel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	widowed

6.(b) Name of husband or wife: 2nd Mrs. Maude L. Reed

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 3, 1878

8. AGE: Years	Months	Days	If less than one day
69	3	11	..... hrs. ..... min.

9. Birthplace: S.C. (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business

FATHER — 12. Name: Harry Reed dec.

13. Birthplace: S.C.

MOTHER — 14. Maiden name: Mitildia Wallace dec.

15. Birthplace: S.C.

16. Informant: son: Mr. Edward Reed

Address: 1769 Willard St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 4-18-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Frazier Funeral Home

Address: 389 Rhode Island Ave., N.W. Wash. D.C.

19. 4-15 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14 1947 at 8 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 April 1947 to 14 April 1947 and that I last saw him alive on 14 April 1947

Immediate cause of death	DURATION
Uremia	
Congestive Heart Failure	4 mo.
Due to: Hypertension, Severe	4-5 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: None obtained

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. L. C. Stevens, Lt(jg)(MC)USNR
H. L. C. STEVENS, Lt.(jg)(MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 4-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

4/23/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

01212

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:
County: Montgomery Co. Md.
City or town: Chevy Chase, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, Institution, or street address where death occurred:
6403 Georgia St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Chevy Chase, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6403 Georgia St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MARGARET M. RENOE

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FM	White	Widow

6.(b) Name of husband or wife: A.J. Renoe
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 12, 1872

8. AGE: Years	Months	Days	If less than one day
74	8	6	..... hrs. ..... min.

9. Birthplace: Ill. (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business
FATHER — 12. Name: James Dougherty
13. Birthplace: Ireland
MOTHER — 14. Maiden name: Mary Sharkey
15. Birthplace: Ill.
16. Informant: James L. Dougherty
Address: 3606 Quesada St. N.W. D.C.
17. Removal (Burial, cremation, or removal. Which?) Date thereof Apr. 19, 1947 (month) (day) (year)
Cemetery or crematory: St. Mary's
Location: Pontiac, Ill.
18. Funeral director: James P. Ryan, Inc.
Address: 317 Ls. Cas. S.E.
19. 4/18/1947 (Date rec'd by registrar) J.M. Eyles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18, 1947, at 6 00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3, 1947, to April 18, 1947, and that I last saw h.. alive on April 18, 1947

Immediate cause of death	DURATION
Uremia	3 days
Due to: Nephrosclerosis	?
Due to: Generalized arteriosclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: C. Herbert Bauers Jr. M.D. M. D. or other
Address: 912 - R. St. N.W. Washington D.C. Date signed: Apr 18, 1947

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

,2108

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

01213

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since 3-22-47
Hospital, institution, or street address where death occurred:
Suburban Hosp.-8600 Old Georgetown Rd.
How long in hospital or institution? Since (3-22-47) Bethesda Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4619 Highland Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war World War I

3.(a) FULL NAME Lee Mr George Rooney

3.(b) Social Security Number 579-03-6094

4. Sex	5. Color or race	5.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife Elsie H. Rooney
6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1877

8. AGE: Years	Months	Days	If less than one day
69	7	10	..... hrs. ..... min.

9. Birthplace New York City
(Town, county, and state)
10. Usual occupation Newspaper Printer
11. Industry or business Times Herald Paper

FATHER
12. Name Michael T. Rooney
13. Birthplace Sligo, Ireland

MOTHER
14. Maiden name Elizabeth Corcoran
15. Birthplace Brooklyn, N.Y.

16. Informant Mrs. Elsie R. Rooney
Address 4619 Highland Ave. Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 5, 1947 (month) (day) (year)
Cemetery or crematory Arlington National Cemetery
Location Arlington, Virginia

18. Funeral director Wm Reuben Pumphrey
Address Bethesda, Maryland

19. 4/3 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-2 1947, at 12 05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 1947, to April 2 1947
and that I last saw h.im alive on April 2 1947

Immediate cause of death	DURATION
Arteriosclerotic heart disease	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Paul D Lantow MD
M. D. or other
Address 7425 Wisconsin Date signed 4/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-C)

01214

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1622 P St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: 1st WW

3.(a) FULL NAME: ROUTT, Willard Trimble

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Neva Routt
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 13, 1890

8. AGE: Years	Months	Days	If less than one day
56	9	10	hrs. min.

9. Birthplace: Mo. (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Raleigh Hotel
FATHER 12. Name: Simpson L. Routt (dec)
13. Birthplace: Mo.
MOTHER 14. Maiden name: Betty Ann Tremble (dec)
15. Birthplace: Mo.
16. Informant: wife: Mrs. Neva Routt
Address: 1622 P St., N. W., Wash., D.C.
17. burial (Burial, cremation, or removal. Which?) Date thereof: 4-25-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.
18. Funeral director: W. W. CHAMBERS
Address: 1400 Chapin St., N. W., Wash., D.C.
19. 4-23 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 April 19 47 at 3:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 April 19 47, to 23 April 19 47
and that I last saw him alive on 23 April 19 47

	DURATION
Immediate cause of death: anemia	7 days
Due to: Chronic nephritis	unknown
Due to: Carcinomatosis	unknown
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Carcinoma of right ureter & chronic nephritis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. L. FLECK, Lt. (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed 4-23-47

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

4/30/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-a)

CERTIFICATE OF DEATH

01215

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Glen Echo, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 years
Hospital, Institution, or street address where death occurred:
#2 Harvard Ave., Glen Echo, Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Glen Echo
(If outside city or town limits, write RURAL and give nearest town)
Street No. #2 Harvard Ave. Glen Echo Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Louisa A. Sands

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	married

6.(b) Name of husband or wife Alexander H. Sands
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 29, 1866

8. AGE: Years	Months	Days	If less than one day
81		23	hrs. min.

9. Birthplace Brookland, N. Y.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name James M. Anthony
13. Birthplace Europe

MOTHER
14. Maiden name Mary Harwood
15. Birthplace

16. Informant Alexander H. Sands
Address #2 Harvard Ave., Glen Echo, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-24-47 (month) (day) (year)
Cemetery or crematory Washington Natl Cem
Location
18. Funeral director W. W. Chambers Co
Address 3072 Mt Pleasant NW.
19. 4/23 19 47 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 19 47, at 11 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 19 47, to April 21 19 47
and that I last saw her alive on April 21 19 47
Immediate cause of death

	DURATION
Pernicious anemia	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE F. M. McChesney M.D.
M. D. or other
Address 4620-36th St. NW Date signed Apr. 22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

01216

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 weeks, 4½ days
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 6 weeks, 4½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 108 N. Adams St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Shook, Mrs. Anna L

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Dr. G. W. Shook
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 1, 1879

8. AGE: Years	Months	Days	If less than one day
67	11	13	..... hrs. ..... min.

9. Birthplace: Wheeling, West Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Robert Griffin
13. Birthplace: Ohio
MOTHER 14. Maiden name: Sara Graves
15. Birthplace: West Virginia
16. Informant: Suburban Hospital Records
Address: Bethesda, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 16, 1947 (month) (day) (year)
Cemetery or crematory: Congressional Cemetery
Location: Washington, D. C.
18. Funeral director: Wm Reuben Humphrey
Address: Bethesda, Maryland
19. 4/14/47 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13, 1947, at 2:15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 26, 1947, to April 12, 1947, and that I last saw her alive on April 12, 1947.

Immediate cause of death	DURATION
Myocardial Failure	One year
Due to: Arteriosclerosis	
Due to:	
Other conditions: Arteriosclerotic gangrene of left foot	

(Include pregnancy within 3 months of death)
Major findings of operations: Gangrene and cellulitis of foot, left. Date of op. 3/18/1947
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Barbara Moulton M.D.
M. D. or other
Address: ..... Date signed: .....

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

01217

Reg. Dist. No. 212

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:
County Montgomery
City or town Dickerson - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 85 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Montg.
City or town Dickerson, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Benjamin Franklin Shreve

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Laura S. Shreve
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 8 - 1862

8. AGE: Years	Months	Days	If less than one day
85	1	18	..... hrs. ..... min.

9. Birthplace Dickerson, Montg. Co. Md
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Daniel T. Shreve
13. Birthplace Maryland
MOTHER 14. Maiden name Margaret Jones
15. Birthplace Maryland
16. Informant Mrs Eulia Fisk
Address Dickerson - Md
17. Burial Date thereof April 29-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Monocacy
Location Beallsville, Md
18. Funeral director William B. Hilton
Address Barnesville, Md
19. 4/28/47 19..... Chas. W. Clagett
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 19 47, at 6:30 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
Dec 22 Exam Case 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Carcinoma of stomach	7 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Brashear M. D.
M. D. or other
Address Gaithersburg Md Date signed 4-26-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01218

Reg. Dist. No. 211

1. PLACE OF DEATH:

County: Montgomery

City or town: Lewisdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Home - Lewisdale, Md.

How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Lewisdale, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. Monrovia

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Glenwood Curtis Smith

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 7, 1920

8. AGE:

Years	Months	Days	If less than one day
26	9	28	..... hrs. ..... min.

9. Birthplace: Lewisdale, Montg. Co., Md.

(Town, county, and state)

10. Usual occupation: Barber

11. Industry or business

FATHER

12. Name: Harry McKinley Smith

13. Birthplace: Montgomery Co.

MOTHER

14. Maiden name: Margaret D. Snowden

15. Birthplace: Frederick Co.

16. Informant: Harry McKinley Smith

Address: Monrovia, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 8, 1947 (month) (day) (year)

Cemetery or crematory: Mountain View Pleasant Grove

Location: Purdum, Md

18. Funeral director: Roy W. Barber

Address: Laytonsville, Md.

19. April 8, 1947 (Date rec'd by registrar) Della V. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5, 1947, at 9 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5, 1947, to April 5, 1947

and that I last saw him alive on April 5, 1947

Immediate cause of death	DURATION
Massive pulmonary hemmorhage (Tuberculosis)	20 minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Partial lobectomy 1942 (Freedmen's Hospital) Date of op. 1942

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Was in Henryton Tbc San 1929, 1938 & 1940

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. McKendree Boyer M.D.

M. McKENDREE BOYER, M.D. or other

Address: Damascus, Maryland Date signed 4-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

01219

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

4/16/47

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months 11 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 months, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Chevy Chase Country Club
(If rural, give LOCATION)

2.(a) If veteran, name war: 1st WW

3.(a) FULL NAME: STANFORD, Homer Reed, Rear Admiral USN Ret. Inact.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): June 26, 1865

8. AGE: Years	Months	Days	If less than one day
81	9	11	... hrs. ... min.

9. Birthplace: Ill.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER
12. Name: Mr. Homer Stanford dec.
13. Birthplace: Mass.

MOTHER
14. Maiden name: Eva Franchif dec.
15. Birthplace: Mass.

18. Informant: daughter: Mrs. Roy Sackett
Address: Yacht INDY, c/o Yacht Club, Eau Gallie, Fla.

17. Cremation
(Burial, cremation, or removal. Which?)
Date thereof: 4-8-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Joseph Gawler

Address: 1756 Penn. Av., NW, Wash., D.C.

19. 7 April 1947
(Date rec'd by registrar)
Mary Charlotte Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 April 1947, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 26 1946, to 7 April 1947 and that I last saw him alive on 7 April 1947

Immediate cause of death	DURATION
Coronary Thrombosis.	2
Due to	
Due to	
Other conditions: Arteriosclerosis - general	2

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: None performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: C. N. WILLIAMS, Capt. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 4-8-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

01220

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:
County Montgomery
City or town Boyd - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montg.
City or town Boyd R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Addie May Stout

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Samuel Stout
6.(c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) 1873 ?

8. AGE: Years 75 ? Months Days If less than one day hrs. min.

9. Birthplace Boyd, Montg Co., Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name John Nicholson
13. Birthplace Md

MOTHER
14. Maiden name Jesse Nicholson
15. Birthplace md

18. Informant Jesse Nicholson
Address Chevy Chase Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 21-47 (month) (day) (year)
Cemetery or crematory Methodist
Location Clarksburg Md.
18. Funeral director William B Hilton
Address Barnesville Md.

19. 4/20 1947 (Date rec'd by registrar) Mrs. C.C. Hilton By mrs c.c.h Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1947, at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 8 1946, to April 19 1947 and that I last saw h.Fe alive on April 3, 1947

	DURATION
Immediate cause of death Hypostatic pneumonia, left kidney	2 years
Due to: arteriosclerotic cardiovascular disease	10 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James R. Kerr M.D. M. D. or other
Address Damascus, Md. Date signed 4/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-21

01221

CERTIFICATE OF DEATH

Reg. Diat. No. 216

WI 3611

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town) Maryland

How long in above place of death?

Hospital, Institution, or street address where death occurred: 6309 Oakridge Rd. Bethesda, Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)

Street No. 6309 Oakridge Ave Bethesda, Md. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Aubrey E. Taylor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

B.(b) Name of husband or wife: Jane E.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 19 1899

8. AGE: Years 48 Months 9 Days If less than one day ..... hrs. ..... min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: Newspaper

11. Industry or business:

FATHER 12. Name: John E. Taylor

13. Birthplace: N.C.

MOTHER 14. Maiden name: Sarah West

15. Birthplace: Virginia

16. Informant: Wife

Address: 6309 Oakridge Ave, Beth. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 24 1947 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln Cemetery

Location: Bladensburg Rd. Wash. D.C.

18. Funeral director: George W. Wise Co., Inc.

Address: 2900 M. St. N.W. Washington D.C.

19. 4/22 1947 (Date rec'd by registrar) Jno E. Jodes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 22, 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 7, 1946, to Apr. 22, 1947

and that I last saw him alive on Apr. 21, 1947

Immediate cause of death	DURATION
Buccal Carcinomatosis	Two.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of supra-clavicular lymph glands.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

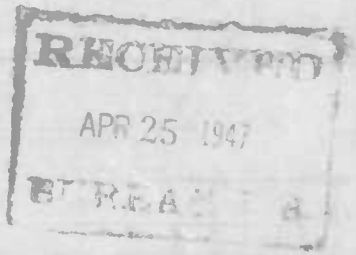
Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. G. Bauerfeind M.D. M. D. or other

Address: Bethesda, Md Date signed 4/22/47



T. Coles.
8012 Old Georgetown Rd.

Evidence for the change of age is shown on G 109 4/24/47

01222

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-4

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Montgomery
City or town: Emory Grove
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Emory Grove
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Isiah Valentine Taylor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Anna Taylor
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): November 1, 1876

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
70	6	12		

9. Birthplace: Montg (Town, county, and state) Md.
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Alexander Taylor
13. Birthplace: Md.

MOTHER
14. Maiden name: Martha McAbee
15. Birthplace: Md.

16. Informant: Anna Taylor (wife)
Address: Emory Grove, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 15, 1947 (month) (day) (year)
Cemetery or crematory: Church Cemetery
Location: Emory Grove, Md.

18. Funeral director: B. L. Saunders
Address: Rockville, Md.

19. April 15 1947 (Date rec'd by registrar) Alvada G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 1947, at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 1946, to April 12 1947
and that I last saw h[illegible] alive on April 12 1947

Immediate cause of death	DURATION
Cardiac Degeneration	
Due to	
Due to	
Other conditions: Contributing.	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Gaithersburg Date signed: April 13 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

01223

CERTIFICATE OF DEATH

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Germantown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? lifetime

Hospital, Institution, or street address where death occurred:
Germantown R.F.D

How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Germantown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Joan Taylor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	S

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1946

8. AGE:

Years	Months	Days	If less than one day
--	4	24	... hrs. ... min.

9. Birthplace: Germantown, Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: James H. Taylor, Jr.

13. Birthplace: Germantown, Md

MOTHER 14. Maiden name: Elizabeth Terry

15. Birthplace: Germantown, Md

16. Informant: James H. Taylor, Jr.

Address: Germantown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4.25.47 (month) (day) (year)

Cemetery or crematory: St. Rose

Location: Cloppers, Md

18. Funeral director: Ernest C. Gartner

Address: Gaithersburg, Md

19. April 24 1947 Glenda L. Poole
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April -24- 1947, at 150 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April -22- 1947 to April -24- 1947

and that I last saw her alive on April -23- 1947

Immediate cause of death	DURATION
Meningitis -	3 days
Due to: Broncho Pneumonia	3 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: William C. Gilles, M.D.
M. D. or other

Address: Gaithersburg, Md. Date signed 4/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50) X

01224

CERTIFICATE OF DEATH

Reg. Diat. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Washington Sanitarium and Hospital

How long in hospital or institution? 7 months

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 2445 15th St., nw (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Thomas, Mrs. Iona

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 16, 1873

8. AGE: Years	Months	Days	If less than one day
73	8	0	hrs. min.

9. Birthplace: Aurora, Indiana (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER — 12. Name: George W. Taylor, Jr.

FATHER — 13. Birthplace: Aurora, Indiana

MOTHER — 14. Maiden name: Mary C. Mulbarger

MOTHER — 15. Birthplace: Versailles, Indiana

16. Informant: Hospital Records and Daughter

Address: Washington Sanitarium & Hospital

17. Cremation (Burial, cremation, or removal. Which?) Date thereof April 19-1947 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Crematory

Location: Prince Georges County, Md.

18. Funeral director: The J. H. Linen Co.

Address: 2901 14th St NW D.C.

19. April 16 1947 (Date rec'd by registrar) J. Milton Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16 1947 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10 1946 to April 16 1947 and that I last saw h[illegible] alive on March 17 1947

Immediate cause of death: Bronchopneumonia — DURATION

Paraplegia

Due to: Metastastic carcinoma

Due to: Breast Cancer

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. F. Geschickter M. D. or other

Address: 1834 Conn Ave Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

01225

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 hrs
Hospital, institution, or street address where death occurred:
Suburban Hosp.
How long in hospital or institution? 2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Monty
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Home
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Robert R. Thompson Jr.

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Clara Thompson
6.(c) If alive, give age: 19 years

7. Birth date of deceased (mo., day, yr.): Oct 18 1907

8. AGE:

Years	Months	Days	If less than one day
39	6	1	— hrs. — min.

9. Birthplace: Nebo Va. (Town, county, and state)
10. Usual occupation: Cook
11. Industry or business: Tasty Diner

FATHER
12. Name: Robt R. Thompson
13. Birthplace: Nebo Va

MOTHER
14. Maiden name: Annaice Webb
15. Birthplace: Chatam Hill Va

16. Informant: Mrs Richard Brown
Address: Barnesville md

17. Burial-Transit (Burial, cremation, or removal. Which?) Date thereof: April 20, 1947 (month) (day) (year)
Cemetery or crematory: Chatham Hill Cemetery
Location: Marion, Virginia

16. Funeral director: Wm. Reuben Thompson
Address: Bethesda, Maryland

19. 4/20 1947 (Date rec'd by registrar) Wm E Johns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 19 47 at 7:50 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Def. Med. Exam Case 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Cerebral hemorrhage	3 hrs.
Due to: hypertension	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Broschart M.D.
Def. Med. Exam. M. D. or other
Address: Gaithersburg md Date signed: 4-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

01226

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
11 Park Valley Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 11 Park Valley Road
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: CLAUDE OLIVER TODD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mildred Virginia
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 12th. 1890

8. AGE: Years	Months	Days	If less than one day
56	6	7	..... hrs. ..... min.

9. Birthplace: Indiana
(Town, county, and state)
10. Usual occupation: Owner Todd Machine Co.
11. Industry or business
FATHER 12. Name: Simeon Todd
13. Birthplace: Ind.
MOTHER 14. Maiden name: Ethel Shaw
15. Birthplace: Ind.
16. Informant: Mrs. Mildred V. Todd
Address: 11 Park Valley Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-22-1947 (month) (day) (year)
Cemetery or crematory: Rock Creek
Location: Washington, D. C.
18. Funeral director: Warner E. Pumphrey
Address: Silver Spring, Md.
19. Apr. 21 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1947 at 10:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1945, to April 19 1947
and that I last saw h[illegible] alive on April 19 1947

Immediate cause of death	DURATION
Generalized arteriosclerosis	1 year
Acute coronary failure	3 Day
Due to: Nephrosclerosis	10 months
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — — — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: W B Waddey M.D. M. D. or other
Address: 943 Bonifant St. Silver Spring Md. Date signed: 4/19/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W. 3200
R1227

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:
Suburban Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8700 Old Georgetown Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Mr Paul E Tolson SR.

3.(b) Social Security Number: 578-03-3229

4. Sex	5. Color or race	6.(a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	

6.(b) Name of husband or wife: Naomi Tolson

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): January 17, 1893.

8. AGE: Years	Months	Days	If less than one day
54	3	11	..... hrs. ..... min.

9. Birthplace: New York State
(Town, county, and state)

10. Usual occupation: Federal Storage Co.

11. Industry or business:

FATHER
12. Name: Henry Tolson
13. Birthplace: England

MOTHER
14. Maiden name: Eva Warren
15. Birthplace: Philadelphia Pa.

16. Informant: Greydon Tolson, Son
Address: 8700 Old Georgetown Rd. Bethesda

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) 4/30/47

Cemetery or crematory: Rockville Union Cemetery

Location: Rockville, Maryland

18. Funeral director: Mr Reuben Pumphrey

Address: Bethesda, Maryland

19. (Date rec'd by registrar) 4/29 1947 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28, 1947, at 1026 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 1947, to April 28 1947 and that I last saw him alive on April 27, 1947

Immediate cause of death	DURATION
Congestive Heart Failure	24 hrs
Due to Coronary Occlusion	24 hrs
Due to Gen. Arterio Sclerosis	5 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Sidney L. Lourie M.D. M. D. or other

Address 3981 Livingston N.W. Date signed 4/25/47

01228

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9420

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Montgomery
City or town Yorktown Village (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1½ yr
Hospital, institution, or street address where death occurred: 4919 Jamestown Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Mont'y
City or town Yorktown Village (If outside city or town limits, write RURAL and give nearest town)
Street No. 4919 Jamestown Rd (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nettie L. Toth (NETTIE L.TOTH)
3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: John Toth
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) April 18 1857

8. AGE: Years 89 Months 11 Days 28 If less than one day ... hrs. ... min.

9. Birthplace Sussex N. J. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business —

FATHER
12. Name John Johnson
13. Birthplace N. J.

MOTHER
14. Maiden name Jennette Wilson
15. Birthplace N. J.

16. Informant Beatrice Summers
Address 4919 Jamestown Rd. Wash 16 - DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 18/47 (month) (day) (year)
Cemetery or crematory Sussex Cem.
Location Sussex, New Jersey
18. Funeral director Martin W. Hysong Co.
Address 1300 - N St. N.W., Washington, D.C.
19. 4/16 1947 Wm E Jobes Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947 at 1:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam. Case 19 to 19
and that I last saw h... alive on 19

Immediate cause of death	DURATION
Coronary occlusion	brief (sudden?)
Due to	
Due to	
Other conditions arterio-sclerosis	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Frank J. Broschart M.D. Dep. Med. Exam. M. D. or other
Address Gaithersburg, Md. Date signed 4-16-47

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-2)

CERTIFICATE OF DEATH

01232

Reg. Dist. No. 2-11

1. PLACE OF DEATH:

County: Montgomery

City or town: Lewisdale MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All Life

Hospital, Institution, or street address where death occurred:

At home - Lewisdale MD/

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Lewisdale. MD.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Josephine Watkins

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Samuel C. Watkins

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): May 6. 1877

8. AGE: Years	Months	Days	If less than one day
69	11	17	..... hrs. ..... min.

9. Birthplace: Frederick County MD.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: William Lee

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Susie Ball Lee

15. Birthplace: Maryland

16. Informant: Roby S. Watkins

Address: Lewisdale Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 24, '47 (month) (day) year)

Cemetery or crematory: Bethesda, Maryland. Md.

Location: Brownings ville. MD

18. Funeral director: Roy W. Barber

Address: Laytonsville, Md.

19. April 24. 1947 (Date rec'd by registrar) Della A. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21 19 47, at 10:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15, 1946, to April 21, 1947

and that I last saw h. E.P. alive on April 20, 1947

Immediate cause of death	DURATION
Arteriosclerotic cardiovascular disease.	10 years.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James P. Kerr M.D. M. D. or other

Address: Westminster, Md. Date signed 4/22/47

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-C

01229

CERTIFICATE OF DEATH

Reg. Dist. No. 2110

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Damascus
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 63 years

Hospital, institution, or street address where death occurred: Home

How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Damascus
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William Silas Watkins

3. (b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Blanche Sadalia Watkins

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): December 17, 1878

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	3	15		

9. Birthplace: Frederick County, Md.
(Town, county, and state)

10. Usual occupation: Retired farmer

11. Industry or business:

FATHER — 12. Name: Rhinaldo Watkins

13. Birthplace: Montgomery Co., Md.

MOTHER — 14. Maiden name: Airy Catherine Flemming

15. Birthplace: Frederick Co., Md.

16. Informant: Wife

Address: Damascus, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 3, 1947 (month) (day) (year)

Cemetery or crematory: Damascus Cemetery

Location: Damascus, Maryland.

18. Funeral director: J. B. Beall, Inc.

Address: Damascus, Md.

19. April 3 1947 (Date rec'd by registrar) Della W. Burdett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1, 1947, at 7:40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1935, to April 1, 1947 and that I last saw him alive on March 31, 1947

Immediate cause of death	DURATION
Carcinoma of stomach (pylorus)	6 mo.?
Duodenal ulcer	8 yrs.
Due to: Chronic myocarditis (advanced) (by EKG)	30 yrs.
Due to: Hypertension	30 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Diagnosis confirmed by Date of autopsy

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. McKendree Boyer M.D.
M. D. or other

Address: Damascus, Maryland Date signed: 4/3/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2) X

01230

CERTIFICATE OF DEATH

Reg. Dist. No. 714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring Maryland (If outside city or town limits, write RURAL and give nearest town)

Street No. Silver Spring R.F.D. #2 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Alfred Wheeler

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Martha Neale Wheeler

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): 25 July 1883

8. AGE:

Years	Months	Days	If less than one day
63	8	26	...hrs. ...min.

9. Birthplace: Chillum, Maryland (Town, county, and state)

10. Usual occupation: Farming

11. Industry or business

FATHER

12. Name: William B. Wheeler

13. Birthplace: Fairland, Md

MOTHER

14. Maiden name: Susan V. Preston

15. Birthplace: Chillum Maryland

16. Informant: Harry S. Wheeler

Address: 316 Williamsburg Dr. Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/23/47 (month) (day) (year)

Cemetery or crematory: St. Marks Cemetery

Location: Fairland, Maryland

18. Funeral director: Wm Reuben Pumphrey

Address: Bethesda, Maryland

19. Apr. 21 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 April 1947, at 11:55 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 1947, to 20 April 1947

and that I last saw h... alive on 20 April 1947

Immediate cause of death: Carcinoma of Colon — DURATION: 2

Due to: — DURATION:

Due to: — DURATION:

Other conditions: — DURATION:

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: William D. Aud M.D. M. D. or other

Address: 9006 Colesville Rd, Silver Spring ...Date signed: 20 April 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-H)

CERTIFICATE OF DEATH

01231

Reg. Diat. No. 716

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, Institution, or street address where death occurred: Suburban Hospital
How long in hospital or Institution? 12 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1220 Blair Mill Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME White John Thomas

3.(b) Social Security Number 577-36-1858

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Hattie A. Lang.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug-31-1885

8. AGE: Years	Months	Days	If less than one day
61	7	13	..... hrs. ..... min.

9. Birthplace Clarksburg W. Va.
(Town, county, and state)
10. Usual occupation Butcher
11. Industry or business

FATHER
12. Name Thomas C White
13. Birthplace Virginia

MOTHER
14. Maiden name Catherine Franks.
15. Birthplace Virginia

16. Informant Sir. Loy T. White
Address 1220 Blair Mill Rd., S.S. Md

17. Removal Date thereof Apr-14-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or ~~crematory~~ Bridgeport Masonic
Location Bridgeport-Harrison Co. W. Va
18. Funeral director Dana E Humphrey -
Address Silver Spring. Md

19. 4/16 1947 Wm E Yokes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947, at 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31 1947, to April 13 1947 and that I last saw h alive on April 13 1947

	DURATION
Immediate cause of death Cerebral hemorrhage	2 wks.
Due to Hypertensive cardio-vascular renal disease	several years.
Due to	
Other conditions Chronic cholecystitis	?

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. none
Autopsy results not done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Frank G Zack M.D.
M. D. or other
Address 8248 Ga. Ave Silver Spring Md. Date signed 4-13-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

CERTIFICATE OF DEATH

9762

01233

Reg. Diat. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 1½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3116 Woodley Rd. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Martha Yarborough

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife Wilbur Fiske
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1890.

8. AGE: Years 56 | Months 5 | Days 4 | If less than one day hrs. min.

9. Birthplace Miami, Fla.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name John C. Hooks
13. Birthplace Augusta, Ga.

MOTHER
14. Maiden name Kadie Aberger
15. Birthplace Indianapolis, Ind.

16. Informant daughter Martha Yarborough
Address Capital Hotel - 51 W 81st St NYC

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/10/47 (month) (day) (year)
Cemetery or crematory City Cemetery
Location Miami, Fla.

18. Funeral director Francis J Collins
Address 3821 - 14 St N.W. Wash D.C.

19. 4/6 1947 Wm E Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1947, at 5 43 P. M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from Jan. 12 1947, to April 6 1947
and that I last saw her alive on April 6 1947

Immediate cause of death	DURATION
Failure of Right Side of Heart	
Due to Asthma	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harry S Berntson M. D. or other
Address 1925 Eye St N W Date signed April 6 '40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 8-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-P) Y

01234

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Mont Co
City or town: Bethesda Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mo
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Mont
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8504 Edmington ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William E Yountain

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Vivian

7. Birth date of deceased (mo., day, yr.): Feb 19, 1880 — 6.(c) If alive, give age ____ years

8. AGE: Years: 67 | Months | Days | If less than one day: ____ hrs. ____ min.

9. Birthplace: Beatrice Neb.
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Railroad

FATHER
12. Name: Aron Yountain
13. Birthplace: —

MOTHER
14. Maiden name: Unknown
15. Birthplace: —

16. Informant: Mrs K. E. Yountain
Address: 8504 Edmington St

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4-10-47 (month) (day) (year)
Cemetery or crematory: Washington DC
Location:

18. Funeral director: W W Chambers Co
Address: 3072 M St NW.

19. 4/10 1947 (Date rec'd by registrar) Wm E Johns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-9-47 19____ at 9:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 47 to 4-9 19 47
and that I last saw him alive on 4-9-47 19____

Immediate cause of death	DURATION
Carcinoma of prostate	yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury: ____ Injured at work?

23. SIGNATURE: Paul D Canton MD M. D. or other
Address: 7425 Wisconsin Ave Date signed 4/10/47

VS A15 9-45.15M

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.